**We are a non urgent service - CHSS are operational Monday-Friday 9-5pm (excluding bank holidays)**

**For any crisis or life-threatening emergency (including suicidal thoughts, self-harm behaviours or**

**critically unwell residents) please call either the resident’s GP, 111 or 999 as necessary.**

**CARE HOME SUPPORT SERVICE REFERRAL**

**Send referral to:** **chss@oxfordhealth.nhs.uk**

|  |  |
| --- | --- |
| **Resident’s Name:** | **Care Home:** |
| **NHS Number:** | **Care Home Telephone Number:** |
| **DOB:** | **Care Home Secure Email Address:**If you do not hold an nhs.net account then the referral will need to be forwarded using egress or other secure platforms. |
| **Ethnicity:** |

|  |  |
| --- | --- |
| **GP’s Name:** | **Surgery:** |
| **GP email address:** |
| **Is GP aware of this referral?**  |

|  |  |  |
| --- | --- | --- |
| **Date of Referral:**  | **Referrer’s Base:** | **Referrer’s Name:****Referrer’s Role:****Referrer’s Contact Details:** |

 **Before completing the referral, please seek guidance overleaf and tick the most appropriate box below.
Please note CHSS are only commissioned to see permanent residents. If the referral is for a respite patient, please speak to their usual GP to access services. If the referral is for a HUB patient, please speak to the HUB team.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PHYSICAL HEALTH TEAM** |  | **THERAPY TEAM** |  | **MENTAL HEALTH TEAM** |  |

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| --- |
| **REASON FOR REFERRAL:** This section must be completed for us to accept your referral. Please give as much detail as possible regarding the reason for referral. Please refer to guidance overleaf regarding information that should be included.  |
| **Has consent been gained from the patient for this referral?** If unable to consent due to capacity, has NOK/family been made aware? Yes/No/Next of kin aware (delete as appropriate)  |

**Insufficient information may result in either a delayed response or further information sought or the referral being rejected.**

