Unpaid Carers Moving & Handling Referral Form

|  |  |
| --- | --- |
| Date |  |
| **Client Details** |
| Name of client |  |
| Name of carer(s) |  |
| Address of client |  |
|  |
| Contact No. |  |
| **Referrer Details** |
| Name |  |
| Occupation |  |
| Contact Email |  |
| Contact No. |  |
| **Training Details** |
| Do they have a care package? | Yes [ ]  | No [ ]  |
| If “no” is the person receiving the training the main carer? | Yes [ ]  | No [ ]  |
| Will this training expediate a discharge from hospital? | Yes [ ]  | No [ ]  |
| What equipment/technique is required to demonstrated?  | Hoist [ ] Tracking hoist [ ] Steady [ ] Bed management system [ ] Glide sheets [ ] Gliding mitts [ ] Stand aid [ ]  |
| Is this equipment in place? | Yes [ ]  | No [ ]  |
| If “no” please give further details |  |
| Does this person have any medical requirements that we should be made aware of? | No [ ]  | If yes, please specify: |
| Location of training  | CTC [ ]  | Clients Home [ ]  | Other: |
| Additional comments |  |
| CTC Comments |  |

\*Following receipt of completed referral a member of CTC will follow up.