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.