**CONFIDENTIAL**

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**COMMUNITY MEDICINES MANAGEMENT TEAM REFERRAL FORM**

*(Send to the relevant Community Medicines Management Team – see over leaf for contact details)*

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| **SERVICE USER DETAILS** |
| NAME OF INDIVIDUAL: ID:      ADDRESS:       D.O.B:      TEL. NO:       |
| HAS THE INDIVIDUAL GIVIEN CONSENT FOR REFERAL? [ ]  **Yes /** **[ ]  No** |
| **NEXT OF KIN/MAIN CARER CONTACT:**NAME & ADDRESS:      TEL. NO:       | **Other Relevant family/friend Contact:**NAME & ADDRESS:      TEL. NO:       |
| **CONTACTS** |
| **GP** NAME & ADDRESS:      TEL. NO:       | **COMMUNITY PHARMACIST**NAME & ADDRESS:      TEL. NO:       |
| **CARE PROVIDER**NAME:      TEL. NO:       | **CARE MANAGER** NAME:      TEL. NO: |
| **REFERRAL INFORMATION** |
| REASON FOR REFERRAL & CURRENT CARE PROVISION:Please include nature of difficulties/concerns, care that the individual currently receives and any other relevant information, e.g. recent discharge from hospital, attendance at day centre etc. |
| **REFERRAL COMPLETED BY** |
| NAME & DESIGNATION:      TEL. NO:       |
| SIGNATURE:       |
| DATE OF REFERRAL:       |

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|  **Community Medicines Management Teams** |
| **Neath Port Talbot Locality** |
| Address:C/O CRTCimla HospitalCimlaNeath SA11 3SU | Tel: 01639 862788Email: sbu.medsmanagementdomiciliarycare@wales.nhs.uk |
| **Swansea Locality** |
| Address:12 FloorOldway Centre36 Orchard StreetSwanseaSA1 5AQ | Tel: 01792 517978Email: abm.crtmedsmanagementteam@wales.nhs.uk |