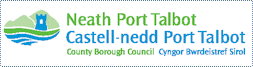
**CONFIDENTIAL**

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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: | |

|  |  |
| --- | --- |
| **Community Medicines Management Teams** | |
| **Neath Port Talbot Locality** | |
| Address:  C/O CRT  Cimla Hospital  Cimla  Neath  SA11 3SU | Tel: 01639 862788  Email: sbu.medsmanagementdomiciliarycare@wales.nhs.uk |
| **Swansea Locality** | |
| Address:  12 Floor  Oldway Centre  36 Orchard Street  Swansea  SA1 5AQ | Tel: 01792 517978  Email: [abm.crtmedsmanagementteam@wales.nhs.uk](mailto:abm.crtmedsmanagementteam@wales.nhs.uk) |