Harlawhill
Day Care Centre

Co-Op Buildings, East loan, Prestonpans, EH32 9ED

Tel No – 01875 814989 E-Mail hhdcc2007@yahoo.com
Scottish Charity No SCO20282

REFERRAL FORM FOR DAY CARE SERVICES

Harlawhill Day Care Centre provides Day Care for frail, elderly, confused and / or vulnerable people living in the Prestonpans area.

The Centre opened on 1st June 1992 and specialises in providing care for older people who need daily support in order to be able to continue living at home.

Our aim is to provide social contact and stimulation in homely surroundings for those who cannot get out of their house without assistance and who require care of supervision for at least part of the day.

We have a specially adapted minibus to bring people to and from the Centre. We also use the bus to get out and about as much as possible for meals out, afternoon tea, visits to garden centres or the seaside etc. Normally people are collected between 09.30 am and 10.30 am and are returned home between 3 pm and 4.30 pm.

A light breakfast, two course hot lunch and afternoon tea are provided/ Activities at the Centre are client led and people are free to do as much or as little as they choose. If a client has a particular interest, we will do our best to provide it. Staff and volunteers are always on hand to provide assistance as and when it is required.

The cost for this service is currently £10 per day although trips may sometimes cost extra but costs will always be kept to a minimum.

If you or if you think someone you know may benefit from attending the Centre, please complete the attached form as best you can and return it to the above address.

We are currently registered to cater for 16 clients per day and there may be a waiting list which is addressed on a needs basis but you will be notified of the current situation once we have assessed your application.

Fiona Mitchell

Centre Manager

CLIENT DETAILS

Name:

Date of Birth:

Address:

Postcode:

Telephone number(s):

E-Mail address:

Marital status:

NEXT OF KIN

Name:

Relationship to client:

Their address:

Their telephone No:

Their e-mail address:

Any other contact(s) in case of an emergency:

DETAILS OF HEALTHCARE PROFESSIONALS

Doctor / Medical Practice:

Telephone number:

District Nurse attends: **YES / NO** **Number of days:**

Home Care Provider: **YES / NO** **Number of days**

Their details:

Social Worker allocated: **YES / NO**

Their details:

MOBILITY

Do you use any of the following aids?

zimmer ☐ **walking frame** ☐ **wheelchair** ☐

walking stick ☐ **spectacles** ☐ **hearing aid** ☐

Generally how is your mobility?: e.g can you walk unaided, can you manage steps, do you require assistance standing or sitting.

PERSONAL CARE

Do you require any adapted cutlery / dishes or drinking aids? Please specify

Do you require assistance with toilet / feeding / other? Please specify

MEDICATION / ALLERGIES

Will you require to take medication whilst in the Centre?

YES ☐ **NO** ☐

TABLETS ☐

INJECTION ☐

Do you have any allergies: (e.g. dairy / nuts / gluten)?

YES ☐ **NO** ☐

If yes, please specify

Are you taking any blood thinning medication? (i.e. aspirin, warfarin etc)

YES ☐ **NO** ☐

Any other relevant medical history: (i.e. Parkinson's, Alzheimer's, stroke, heart condition, diabetes)

YOUR HOME

Is there parking at or near your address?	**YES ☐**	**NO ☐**
Do you have a key safe?	**YES ☐**	**NO ☐**
Is there easy access to your door	**YES ☐**	**NO ☐**
Do you have a ramp?	**YES ☐**	**NO ☐**
Are there steps?	**YES ☐**	**NO ☐**
Do you need help to get out?	**YES ☐**	**NO ☐**
Do you need help to get ready?	**YES ☐**	**NO ☐**

REASON FOR REFERRAL

Why are you being referred? (i.e. social isolation, carer stress / respite, depression, dementia etc

IF YOU ARE MAKING THIS REFERRAL ON BEHALF OF SOMEONE ELSE THEN PLEASE COMPLETE THE NEXT SECTION

Is the person being referred aware of this referral?

YES ☐ **NO** ☐

If not then do they have the capacity to give consent?

YES ☐ **NO** ☐

Is a Power of Attorney in place?

YES ☐ **NO** ☐

If yes are you one of the named attorney's?

YES ☐ **NO** ☐ **N/A** ☐

PERSON MAKING THE REFERRAL

If you are not the proposed client or the next of kin mentioned above then please provide your details below:

NAME:

ADDRESS:

CONTACT DETAILS:

RELATIONSHIP TO PERSON BEING REFERRED: (i.e. Doctor, Nurse, friend, Carer etc)

ABOUT YOU (CLIENT)

Please provide some details about yourself so we can get to know you a bit better. Where did you grow up, go to school, work, your hobbies and interests? Are there any foods that you dislike or really like, what is your favourite film, what music do you like to listen to, what are your favourite games (dominoes / bingo / cards / quizzes?)

Any information you can offer regarding the person you are referring's "life story" - for example grand/children's names, birthplace, work history, hobbies etc. - would be much appreciated. This knowledge helps staff to enable clients (especially those with a degree of confusion) to settle into the centre. Please use the space below and add a continuation sheet if needed!