Dear Referrer,

Please complete **all fields** below and return completed form to Millennium Care Services as soon as possible.

|  |  |  |
| --- | --- | --- |
| Question  |  | Admin use only  |
| **Date referral made:** |  |  |
| **Have you made tel. enquiry previously?** | Yes/ No If Yes, please state date referral made and to who you spoke with. |  |
| **Have you received the referral process?** | Yes/ No |  |
| **Initials of the person** |  |  |
| **Current address/ location:** |  |  |
| **Age:**  |  |  |
| **Diagnosis and brief summary of needs:** **(Please give as much detail as possible)**  |  |  |
| **Type of Service Design Required:****(Please be mindful of specifics around capable environments)**  |  |  |
| **Contact details of referrer – telephone and email:** |  |  |
| **Type of information required for referral to proceed:****Consider:****Risk assessments and risk management plans already in situ.****Support plans** **Peron Centred Plans****Safe Me relapse prevention plans****CTR action plan****Decision support tool** **MDT assessments and diagnostic reports****Tribunal or DoLS reports** **Previous relevant chronology** **Relevant previous incident reports**  |  |  |
| **Potential timescales for assessment to proceed,****Expected date of service start**  |  |  |

**Thank you for taking the time to complete the attached form. If you have any further clarity then please do not hesitate to contact Millennium Care Services.**

**Kind Regards**



**Lynn Dougan**

**Head of Care**