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**