**Referral to Medicines Review in Care Homes Service**

This form is for electronic completion by a GP or the Quality in Care Team

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| Name and position of referrer | Date of referral |
|  |  |
| Address and contact details (email and telephone number) of referrer. | |
|  | |
| Name & Address of Care Home. | |
|  | |
| Care Home bed capacity | |
|  | |
| Type of Care Home *(Click in the box below and select from the drop down list)* | |
| Choose an item. | |
| Name and Contact details (email and tel) of carehome manager and parent organisation. | |
|  | |
| If this referral is from a GP practice, please provide a GP contact.  (Name, email & practice) | |
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| **Reason for Referral** | |
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| 1. What is the reason for the referral? | |
|  | |
| 1. Do any of the following reasons apply to referral?   *(Click in the box below and select from drop-down menu)* | |
| Choose an item. | |
| If yes to any of the above, please provide further details. | |
|  | |
| 1. Is the provider aware of the referral?   *(Click in the box below and select from drop-down)* | |
| Choose an item. | |
| If no, please provide the reasons. | |
|  | |
| 1. What is the desired outcome? | |
|  | |

Please email your referral to [bucks.mmt@nhs.net](mailto:bucks.mmt@nhs.net) using **“Referral to Medicines Review in Care Homes Service”** in subject heading.

**For Team Use Only**

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| Name of person triaging referral | Click here to enter text. | Planned action – others including  Click here to enter text. |
| Date triaged | Click here to enter text. |
| Priority Score | Click here to enter text. |
| Planned Action *(Select from drop-down)* | Choose an item. |
| Planned Start Date | Click here to enter text. |
| Date added to workplan | Click here to enter text. |
| Date referrer contacted | Click here to enter text. |
| Request any support plans from the referrer or safeguarding reports on medications | Click here to enter text. | Click here to enter text. |