**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. |
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| Name & Address of Care Home. |
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| 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.  |
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| 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?
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| 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?
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Please email your referral to 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. |