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| **NHS Medway Foundation Trust**  **Rapid Access Clinics Elderly Care (RACE)**   1. For all administrative or booking confirmations please call 01634 833812 2. Alternatively you can contact us [medwayft.race@nhs.net](mailto:medwayft.race@nhs.net) | | | | |
| **Date:** | | | | |
| **Please complete all sections:** | |  | | |
| **Patient Details:** | | | | |
| Patient name: |  | | | |
| D.O.B: |  | | | |
| Address: |  | | | |
| Telephone No.: |  | | | |
| Contact detail of NOK: |  | | | |
| Mobility: | Independent □ Walking aid □ Wheelchair □ Bed bound □ | | | |
| Will patient need transport to clinic? Please give details. | YES □ NO □ | | | |
| **GP Details:** | | | | |
| Surgery Name & Address: |  | | | |
| GP Contact number/ email address: |  | | | |
| **Current services:** | | | | |
| Does the patient have carers? | YES □ NO □ | | | |
| Privately arranged □ Social services □ Family only □ | | | |
| Details of frequency, type of help provided, contact details of care agency: | | | |
| **Known to other services:** | | | | |
| Please state service patient known to:  . | District Nurses □ | | Community Cardiology □ | Community Falls □ |
| Community Physio □ | | Palliative Care □ |  |
|  | | Other Please state: | |
| **Details of frequency, nature of visit(s):** | | | |
| **Clinic:** | | | | |
| I would like to refer the patient to: | Elderly Care RACE Clinic □ | | | |
| Falls Clinic □ | | | |  |
| Parkinson’s Clinic □ | | | |
| Reason for Referral: |  | | | |  |
| **Refer Details:** |  | | | |  |
| Name |  | | | |  |
| Role / Team |  | | | |  |
| Contact Telephone & Email |  | | | |  |

**Elderly Care Physician Use Only**

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| **Date:** | **Urgent** □ | **Routine** □ |
| **RACE Clinic** □ | **Falls Clinic** □ | **Parkinsons Clinic** □ |

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| **Comments:** |
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