Falkirk
Health and Social Care
Partnership

Caledonia Service
Dollar Park, Falkirk, FK1 5RU
Telephone: 01324 501720
Email: caledonia.service@falkirk.gov.uk
www.caledoniaservice.com

Referral Form

All information received by Caledonia Service is held strictly confidential and will not be shared with outside agencies without your consent.

We recommend that prospective service users visit our web site www.caledoniaservice.com before filling out this application form with their referrer. This gives them the opportunity to learn more about the service and programme offered, and whether it will meet their needs and achieve their outcomes.

Once completed please send to the address above.

HEALTH AND SOCIAL CARE INTEGRATION	
CAN YOU PROVIDE AN UP TO DATE VERSION OF THE FOLLOWING DOCUMENT?	
Single Shared Assessment	Yes ☐ No ☐ If Yes go to section 3
PLEASE MAKE SURE ALL DOCUMENTS ARE INCLUDED WHEN RETURNING THE APPLICATION FORM	

SECTION 1

SERVICE USER DETAILS			
Title		**DOB**	
First Name		**Home Phone Number**	
Last Name		**Mobile Phone Number**	
Address			
Post Code		**Email Address**	
Emergency Contact Details and Number			
Details of Primary Diagnosis			

SECTION 2

NETWORK OF SUPPORT	
The service works in partnership and supports the regular flow of information between all professionals in support of service users.	
Name of Referrer	
Address	
Phone Number	
Email Address	
MEDICAL / SOCIAL WORK CONTACTS	
CPN DETAILS	
Name	
Address	
Postcode	
Phone Number	
E-mail Address	
SOCIAL WORKER DETAILS	
Name	
Address	
Postcode	
Phone Number	
E-mail Address	

GP DETAILS	
Name	
Address	
Postcode	
Phone Number	
E-mail	

PSYCHIATRIST / PSYCHOLOGIST DETAILS	
Name	
Address	
Postcode	
Phone Number	
E-mail	

OTHER SUPPORT (E.G. SAMH, PENUMBRA ETC.)	
Name	
Address	
Postcode	
Phone Number	
E-mail	

SECTION 3

BACKGROUND HISTORY (Please include the following)
Reason for Referral?
What outcomes have been identified?
How can the Service Support?
Any physical health needs /support required?
Any other relevant information to support the application? e.g. Care Partners Care Plan / Risk Assessments

SECTION 4

Please ensure that you have attached all relevant documents / completed all sections of the Referral Form before returning it to us as incomplete forms will delay the referral process and be returned to referrer.

Once we have received and processed all the information we will contact you to attend the service and agree a placement start date. However if you do not hear from us within 4 weeks, please contact us and speak to a member of staff on 01324 501720.

Service User Signature: ……..

Date: ……..

Referral Source Name: ……..

Referral Source Address ……..

……..

……..

Referral Source Signature ……..

Date: ……..

Completed forms to be returned to address below. It should be marked PRIVATE and for the attention of:

The Manager
Caledonia Service
Dollar Park
Camelon Road
Falkirk
FK1 5RU