LiveLife MILTON KEYNES

Social Prescribing Service for all adults 18+living in Milton Keynes

Social Prescribing Referral Form

Milton Keynes age UK

CLIENT DETAILS	
Date of referral:	NHS number**:**
Clients Name:	Named GP:
Date of birth:	GP Practice Address:
Address:	Contact Number(s) Email:
Has the client consented to this referral? ☐	

Current Health Conditions: (Please tick as many as appropriate)

Long Term Conditions: yes ☐ no ☐ Please give details: _____

Frailty (65+): yes ☐ no ☐ Please give details: _____

Mental Health: yes ☐ no ☐ Please give details: _____

Complex Social Needs: yes ☐ no ☐
Loneliness or Isolation: yes ☐ no ☐
Learning Disability yes ☐ no ☐

What would the client like to achieve from Social Prescribing: (Please tick all that apply)

Health and Wellbeing: improved wellbeing☐ improved quality of life☐ improved physical health☐ reduced health risks☐ improved mental health☐ improved emotional wellbeing☐ improved spiritual wellbeing☐ changed lifestyle behaviour☐ increased independence☐ increased knowledge☐ other☐ _____

Social: community groups☐ links with peers☐ carer support☐ family support☐ neighbourhood groups☐ cultural engagement☐ social connections☐ other☐_____

Learning: qualification☐ skills☐ self-management☐ health☐ other☐_____

Work/Employment: volunteering☐ employment☐ self-employment☐ employability☐ other☐ _____

Finance: debt resolution advice☐ income increased☐ fraud avoidance☐ access to benefits☐ hardships addressed☐ other☐_____

Housing: improved conditions☐ safer home☐ home adaptations☐ neighbourhood relationships☐ ability to pay rent☐ other☐ _____

Please outline the reasons for this referral

Does the client need any extra support to enable them to fully engage with Social Prescribing? Reasonable adjustments, communication, language

Risk Information
Is there a risk of harm to self or others: yes ☐ no ☐ please give details:
Is the client known to be abusing substances or alcohol: yes ☐ no ☐ please give details:
Is the client currently using A class drugs: yes ☐ no ☐ please give details:

Referrer Information	
Name of referrer: Role/Relationship to client:	Contact Number Email address
Company/Organisation	Address
Is the client still open to your service? yes ☐ no ☐	If no, date of discharge:

Please provide details of other professionals/organisations involved:		
Name	Role	Contact Details

Thank you for the referral
Please send to: **Live.Life@nhs.net**
or post to: Social Prescribing LiveLife, AgeUKMK, The Peartree Centre, 1 Chadds Lane, Peartree Bridge, Milton Keynes, MK6 3EB