**P2C Personal Health Budget** Referral Form

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| **Section 1** – Personal Details |

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| Patient's surname: |  |
| Patient's first name: |  | Date of birth: |  |
| Preferred language:Interpreter required? Y/N |  | GenderMale  Female  Intersex  Non-binary  Prefer not to say |  |
| QA Number: |  |
| Address: |  |
|  |
| Home telephone: |  | Mobile telephone: |  |
| Email address: |  |
| If you're acting on behalf of someone, please provide your name, address and contact telephone number:   |
| Name: |  |
| Address: |  |
|  |
| Telephone: |  | Mobile: |  |
| Relationship to Personal Health Budget applicant: |  |
| Do you have Financial Power of Attorney? |  | Yes | [ ]  | No | [ ]  |
| Do you have Health and Welfare Power of Attorney? |  | Yes | [ ]  | No | [ ]  |
| If this person lacks capacity, has a Capacity Assessment been completed for this referral? | Yes | [ ]  | No | [ ]  |
| Date of Capacity Assessment (if applicable): |  |
| Does the patient or individual with LPOA consent to Partner2Care accessing their medical records? | Yes | [ ]  | No | [ ]  | N/A\* | [ ]  | \*If patient unable to consent and no LPOA in place. |
| Best interest Meeting Outcome: |  | Date: | [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] |
| Communications needs/preferences | BSL: Other: | Date: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is this referral new? | Yes | [ ]  | No | [ ]  | A re-referral? | Yes | [ ]  | No | [ ]  |
| Is there currently an agreed care package already in place? | Yes | [ ]  | No | [ ]  |
| Is the current package of support to remain with current providers of package? **Possibly change to PHB if agreed** | Yes | [ ]  | No | [ ]  |
| Is there an agreed indicative budget? | Yes | [ ]  | No | [ ]  |
| If an indicative budget is in place, when was it awarded? | Date: |  |
| How much is this budget? **Current care costs**  |   |
| Are PAs self-employed?  | Yes/No |
| If there is no indicative budget refer to the ICB before proceeding as this is a requirement of the assessment |  |
| Is there a completed support plan? **See record of needs and DST** | Yes | [ ]  | No | [ ]  |
| Will the package be a direct payment? If yes, please select which services you will require from Partner2Care: | Yes | [ ]  | No | [ ]  |
| 1. DBS
2. Payroll
3. Training
 | Yes | [ ]  | No | [ ]  |
| Yes | [ ]  | No | [ ]  |
| Yes | [ ]  | No | [ ]  |
| 1. Care Plan
 | Yes | [ ]  | No | [ ]  |

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| **Section 2** – Referral Information |
| Has this indicative budget been considered with due diligence for the package of care and value as advised by relevant ICB before referring to Partner2Care? | Yes | [ ]  | No | [ ]  |
| Has POC had scrutiny and agreement for employment of family members if applicable? NA | Yes | [ ]  | No | [ ]  |
| Are any PAs in post-paid over the ADC pay rate – if yes – please discuss referral is appropriate before proceeding | Yes | [ ]  | No | [ ]  |
| Has a Record of Needs been attached with this referral form? | Yes | [ ]  | No | [ ]  |
| Has Continuing Healthcare been awarded or is an assessment on-going? | Yes | [ ]  | No | [ ]  |
| Has a DST been attached with this referral form? **(Please note we are unable to accept referrals without a DST\*) \*Excludes Fast Track/End of Life referrals** | Yes | [ ]  | No | [ ]  |
| Does the package have a self-employed carer in place already?**\*If yes then not a suitable referral to Partner2Care, unless the person is willing to come on the package as an employed PA** | Yes | [ ]  | No | [ ]  |
| What are the patient's presenting problem / diagnosis? Please give details: |
|  |
| Does the initial visit from Partner2Care require the presence of more than 1 assessor due to any risk factors? If yes, please provide details | Yes | [ ]  | No | [ ]  |
| If in receipt of Continuing Healthcare funding when is the next review? | Date: |  |
| When was the Continuing Healthcare funding received? | Date: |  |
| Referral acknowledged by: |  |
| Date acknowledged: |  | Accepted: | Yes | [ ]  | No | [ ]   |
| If not accepted, please explain reason why action is required: |
|  |
| Referrer's name: |  |
| Referrer's address: |  |
|  |
|  | Postcode: |  |
| Referrer's telephone: |  |
| Date of form completion: |  |

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