Surrey Downs Social Prescription Service

Once complete, please send this referral to: socialprescribing@epsom-ewell.gov.uk
When sending emails outside of NHS mail use [secure] at the start of the email subject.
You will receive confirmation that the referral has been received within 2 working days. The resident will be contacted to discuss support available to them within 7 working days.

Patient's Information:

Title: Mr/Mrs/Miss/Ms/other (please specify) -			
First Name:		Surname:	
Date of Birth:		Age:	
Address		Postcode:	
		NHS Number: (if known)	
Email:		Telephone:	

Does the patient have any communication or access needs?

- ☐ Difficulty hearing, or needs hearing aids, or needs to lip-read
- ☐ Difficulty with memory or ability to concentrate, learn or understand
- ☐ Difficulty speaking or using language to communicate or make needs known
- ☐ Limited mobility or uses a wheelchair

Data Protection:

The client has been made aware of and understands the below statement, and gives consent for this referral to be made:

☐ Yes ☐ No Date: _____

The information you have provided in this referral will be passed to Social Prescribing Service at Epsom and Ewell Borough Council with your consent. The Council will not accept a referral whereby consent has not been given

Your information will be treated as confidential by the Council and only used for the express purpose of being able to provide you a service. It will be used in line with the General Data Protection Regulation, and the Council's Privacy Notice.

A copy of the Council's Privacy statement is available on the Council's website:

https://www.epsom-ewell.gov.uk/council/about-council/data-protection/privacy-and-cookies/social-prescribing-services-privacy-notice

Who made this referral? *To be completed by referrer*

☐ Self-referral: referrer details are the same as patient details provided above.

Please provide your details of your GP Surgery below:

GP Surgery		Telephone	

☐ Professional referral: please complete referrer details below

First Name:		Surname:	
Organisation/GP surgery:			
Telephone:		Email:	

If you consent to someone else being contacted to discuss this referral, or to be notified to be notified of the outcome, please give their contact details:

Name:		Relationship to Patient:	
Organisation:			
Telephone:		Email:	

<u>What Support is Required?</u> *To be completed by referrer*

What is the main area the individual would like support with?

- ☐ Emotional wellbeing (e.g. stress, anxiety, low mood, personal motivation)
- ☐ Social isolation or loneliness (e.g. befriending, finding social clubs, joining community activities, transport)
- ☐ Skills and job roles (e.g. training, volunteering and moving towards employment)
- ☐ Healthy lifestyle (e.g. maintaining a healthy weight, getting active)
- ☐ Basic living concerns (e.g. home maintenance, adaptations and safety)
- ☐ Specialist advice (e.g. housing, welfare, benefits, debt)
- ☐ Has recently fallen or is at risk of a fall
- ☐ Looking after someone else who couldn't manage without them

Why and how do you think you or the individual will benefit from a social prescription?

Is there any reason why you/the patient should not exercise?

☐Yes ☐No

Please give any details: