Version 11.06.19

Barnsley Integrated Community Equipment Service
Equipment Referral Form (ER1)

Unit 33, Grange Lane Industrial Estate, Stairfoot, Barnsley, S71 5AS **Tel.: 01226 – 320990**

SECURE EMAIL: barnsley.equipmentservice@nhs.net

Decision to supply date: (referrer)	Date requested: <Today's date> (referrer)	Date received (CES):

SERVICE USER DETAILS

Title: <Patient Name>	Surname: <Patient Name>	Forename(s): <Patient Name>	NHS / SSIS No.: <NHS number>
Address: <Patient Address> Post Code: <Patient Address>		Date of Birth: <Date of Birth>	Ethnicity: <Ethnicity>
		Height?: <Latest Height>	Weight? <Latest Weight>
Tel. No.: <Patient Contact Details>	Mobile No.: <Patient Contact Details>	GP name: <GP Name> GP address: <Organisation Address> GP tel. no.: <Organisation Details> GP Practice Code: <Organisation Details>	
Care Home? ☐ **Yes** ☐ **No** **If yes,** ☐ **RH** ☐ **NH**			
Alternative contact information: Name:		Relationship to service user: Tel. No:	

EQUIPMENT REQUESTED (STOCK ITEMS)

Specify: no. items, required size / risk level for pressure care mattresses / height and/or width of equipment for fitting purposes.

Qty	Item(s) – include required size / specification.	For adjustable items state ht / width settings etc. (cm or inches)	Short (S) or long-term (L) loan?

☐ Delivery only ☐ Delivery and fit ☐ Already issued ☐ To collect from store

HOME ENVIRONMENT

☐ Bungalow ☐ House ☐ Flat (ground floor) ☐ Flat 1st floor and above – is lift working?	☐ **Yes** ☐ **No**		
Access issues - from road / steps?	☐ **Yes** ☐ **No**	Sufficient space for equipment?	☐ **Yes** ☐ **No**
Key safe? (tel. BICES with details)	☐ **Yes** ☐ **No**	Other environmental risks at property?	☐ **Yes** ☐ **No**
Details re. home environment from above / delivery instructions e.g. *go to back door / knock loudly etc.:*			

REFERRAL PRIORITY

Hosp in-patient? ☐ **Yes** ☐ **No**	If yes, Hospital/Ward?	Discharge date:	Equip. needed for hosp. discharge? ☐ **Yes** ☐ **No**	**LDOL?** ☐ **Yes** ☐ **No**

☐ **Priority 1 (24 hours)** ☐ **Priority 2 (3 working days)** ☐ **Priority 3 (7 working days)**

I am competent in prescribing for this piece(s) of equipment and will ensure the service user (and carer) is given clear instructions on how to use the equipment safely and correctly. All relevant sections of the form have been completed and contact information is accurate and up-to-date.

Name: <Sender Name>	Job title:	Staff ID No:
Signature:	Work Base:	Tel. No.: <Organisation Details>

Please note: Missing or inaccurate information may lead to delays in arranging equipment deliveries/collections.

E-mail address (if you wish to receive electronic updates):	Date: <Today's date>
Name and signature (for authorisation if needed):	**Date authorisation:**

Please note: Missing or inaccurate information may lead to delays in arranging equipment deliveries/collections.