**Health Inclusion Clinic – Referral Form**

We will accept referrals for the following patients:

* Refugees, asylum seekers, refused asylum seekers, undocumented migrants or people with no recourse to public funds AND who have had difficulty accessing mainstream General Practice (usually as they have no address due to homelessness or sofa surfing)
* We will not see people who are currently registered with their local GP
* We request that attempts have been made to register the patient with their local GP

**Please email completed referral forms to** [**gst-tr.referralsHIT@nhs.net**](mailto:gst-tr.referralsHIT@nhs.net)

We will let you know if the patient is suitable for our service and when their first appointment will be. *Please do not make any appointments before a referral has been accepted.* We will contact the patient directly to make an appointment at our clinic.

If you would like to discuss any cases, our GPs are available at the surgery for telephone contact on the above number on *Tuesdays and Fridays*. At other times, please phone the Health Inclusion Team on 020 3049 4700/4555 and leave a message.

\* please delete as appropriate

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT DETAILS | | | |
| First name | |  | |
| Surname | |  | |
| DOB | |  | |
| Gender | | MALE/FEMALE\* | |
| Address | |  | |
| Telephone number | |  | |
| Country of Origin | |  | |
| Ethnic Origin | |  | |
| Religion | |  | |
| Language(s) | |  | |
| Interpreter required | | YES/NO\* | |
| Interpreter preference | | Female/male/no preference\* | |
| REFERRAL CRITERIA | | | |
| Immigration status | | |  |
| Home Office ID number | | |  |
| Date of arrival in UK | | |  |
| Current accommodation | | | Street homeless/Hostel/Sofa surfing/Staying with friends/church/mosque/Other\* |
| Contact address | | |  |
| Have you or the patient attempted to get registered with a GP? | | | YES/NO\* |
| If YES, what were the barriers to getting registered? | | |  |
| If NO, why has registration with a GP not been attempted? | | |  |
| REASONS FOR REFERRAL | | | |
| What are the reasons for the referral? Why does the patient wish to see a GP? What are their medical problems and treatment so far? | | | |
| AGENCIES INVOLVED | | | |
| Solicitor | Address:  Tel:  Fax:  Email: | | |
|  | Address:  Tel:  Fax:  Email: | | |
|  | Address:  Tel:  Fax:  Email: | | |
| What action has been taken by your organisation and other agencies?  e.g. Section 4 application, HC2 application, referral to Medical Foundation etc. | | | |
| OTHER RELEVANT INFORMATION | | | |
|  | | | |
| REFERRERS DETAILS | | | |
| Referrer’s name |  | | |
| Address |  | | |
| Telephone number |  | | |
| Fax number |  | | |
| Email address |  | | |
| Date |  | | |