

Waterford Integrated Care for Older People (W.I.C.O.P) Hub

Referral Form

Demographic details		Referrer details	
Name: Address:		Name: Address:	
DOB: Med card Number:		Email : Contact Number:	
Date of referral:			
WICOP Inclusion Criteria		Exclusion Criteria	
Over 65 years <input type="checkbox"/>		Sole purpose of referral regarding home care package (refer to relevant PHN in the area) or Respite (refer to DON in relevant area)	
Within Waterford Catchment area <input type="checkbox"/> (area directory , see WICOP website)			
Consent			
Patient consents to referral to W.I.C.O.P: Yes / No Does the patient consent to us contacting a nominated person . (This may include a telephone call to the nominated person to, for example, arrange appointment or gain collateral : Yes/ No Nominated person's name _____ Contact details _____ Relationship to patient _____			
Main Issue (please specify)			Tick
Falls :	Greater than 1 fall in 6 months, OR 1 fall in past 6 months causing significant injury, OR Suspected syncope causing falls		
Frailty:	For patients with more advanced frailty who are having difficulty in more than one domain due to progressing frailty		
Memory :	Please include details of memory screening score and details of impact on function e.g. MMSE below 25/30 unless clinical signs of impairment are evident and/or significant deficits impacting on day to day function		
Movement Disorder :	Patients requiring assessment for movement disorders e.g. PD		
General:	Patients who do not fit above criteria but require specialist geriatric team input		
Additional information / clinical question :			
GP's perspective of Social Circumstances: (e.g. home help services, family support)			
GP's Knowledge of other agencies involved (e.g. Primary care team, Alzheimer's Society, safeguarding, sage, addiction services, counselling or other tried interventions)			
Please also attach	1. Detailed referral letter <input type="checkbox"/> 2. List of current Medications <input type="checkbox"/> 3. Past medical History / Medical details <input type="checkbox"/> Print out from GP software Package will suffice		
Referrer Name:			

Post to WICOP Hub, c/o Age related Care Unit, St Teresa's,UHW.
Email to WICOP.UHW@hse.ie; Fax: 051-848882