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| **THIS REFERRAL FORM MUST BE COMPLETED IN FULL TO FACILITATE SAFE CLINICAL TRIAGE & PRIORITISATION OTHERWISE THE REFERRAL WILL BE REJECTED** | | | | | | | | | | | |
| **SURNAME:** | | **FIRST NAME(S):** | | | | | | | | **MALE**  **FEMALE** | |
| **D.O.B:** | **NHS NUMBER:** | | | **MRN NUMBER:** | | | | | | **ETHNICITY (see code list):** | |
| **CURRENT HOME ADDRESS:**  **POSTCODE:** **BOROUGH:**  **MOBILE/TEL:**  **ADDRRESS PERMANENT** OR **TEMPORARY**  ? | | | | | | | **GP NAME**:  **GP ADDRESS**:  **POSTCODE:** **BOROUGH:**  **DIRECT ACCESS TEL:** | | | | |
| **PRIMARY LANGUAGE SPOKEN**: | | | | | | | **INTERPRETER REQUIRED? YES**  **NO** | | | | |
| **IS PATIENT HOUSE-BOUND: YES**  **NO** | | | | | | | **TRANSPORT:** **MEETS CRITERIA?** **YES  NO** | | | | |
| **HAS REFERRAL BEEN DISCUSSED & AGREED WITH PATIENT: YES  NO** | | | | | | | **N.O.K NAME, RELATIONSHIP & CONTACT DETAILS**: | | | | |
| **CONSENT GIVEN TO SHARE INFO: Yes  No** | | | | | | | **COGNITIVE IMPAIREMENT: Yes  No** | | | | |
| **DOES PATIENT LIVE ALONE: YES  NO** | | | | | | | **HOME ACCESS:**  Carer or relative will open door  Key safe (list code) Sensory impairment Type: | | | | |
| **RELEVANT MEDICAL HISTORY** (Long term conditions, diagnosis, treatment, investigations etc. Please include medical discharge summary): | | | | | | | | | | | |
| **CURRENT MEDICATION** (include route, any difficulties taking if known – attach medication list/TTA/Discharge summary) | | | | | **MEDICATION ADMINISTRATION PRESCRIPTION (for community nursing only):** | | | | | | |
| **DRUG:** | | | | **DOSE:** | | **ROUTE:** |
| **ALLERGIES/SENSITIVITIES** | | | | | **FREQUENCY:** | | | | **START DATE:** | | **STOP DATE:** |
| **AUTHORISING SIGNATURE, NAME & DESIGNATION:** | | | | | | |
| **CURRENT MOBILTY & FUNCTIONAL BASELINE** (note any additional information)**:**  **Fully mobile:** YesNo  **Assistance of 1:** Yes No  **Able to do stairs:** YesNo | | | | | | | | | | | |
| **REASON FOR THIS REFERRAL AND EXPECTED OUTCOME** **– SEE OVERLEAF AND SELECT ONE PRIMARY NEED:**  **UNPLANNED**  **PLANNED** | | | | | | | | | | | |
| **CAN PATIENT BE SEEN AT HOME? Yes  No  CAN PATIENT BE SEEN IN CLINIC? Yes  No**  **\*If transport required – must be eligible as per criteria** | | | | | | | | | | | |
| **IDEAL DATE OF FIRST VISIT (**ultimately determined by service following clinical screening & triage**):** | | | | | | | | | | | |
| **HOSPITAL DISCHARGE INFORMATION (**include medical, nursing & therapy discharge summaries & any relevant information, copy of hospital drug chart**).** | | | | | | | | | | | |
| **ADMISSION DATE**: | | | **DISCHARGE DATE**: | | | | | **ADMISSION REASON**: | | | |
| **DETAILS OF EQUIPMENT:** | | | **DETAILS OF PACKAGE OF CARE:** | | | | | **ADDITIONAL DISCHARGE INFO:** | | | |
| **HEALTH & SOCIAL RISKS:**  **Risk to healthcare staff: Yes**  **No**  **If yes, please state risk:** | | | | | | | | | | | |
| **OTHER SERVICES CURRENTLY INVOLVED & FREQUENCY OF INPUT:** | | | | | | | | | | | |
| **SAFEGUARDING CONCERNS/ALERTS? YES  NO  \*PLEASE NOTE OR CONTACT US IF YOU PREFER TO DISCUSS** | | | | | | | | | | | |
| **SELECT COMMUNITY SERVICE REQUIRED – CHOOSE ONE SERVICE ONLY BELOW** | | | | | | | | | | | |
| **Unplanned Care (WITHIN 24 HOURS)** | | | | | | | | | | | |
| **Admission Avoidance service:**  Provision of prescribed treatments for diagnosed infections (Chest infection, UTI, cellulitis)  Monitoring general decline whilst diagnosis reached  Blocked catheters  Constipation management  Urinary retention management  Post Fallssupport | | | | | | **Palliative Care Provision service:**  Symptom management – urgent nursing intervention  Equipment provision – urgent nursing intervention  Is the person suspected to have days/weeks left to live? Yes  No | | | | | |
| **Urgent medication administration:**  Insulin administration  Tinzaparin | | | | | |
| **Planned Care (BEYOND 24 HOURS)** | | | | | | | | | | | |
| **Home Nursing service (for house-bound only):**  Medication administration (excl. oral/prompting)  Wound care – simple and complex  Pressure Ulcer: Yes  No  If yes: Grade & site  Suture/clip removal  Continence assessment  Bowel care Catheter care  Pressure area careEquipment provision  Flu vaccination  **Home Phlebotomy service** **(house-bound only):**   |  |  |  | | --- | --- | --- | | U&E | Calcium Profile | FBC | | HBA1C | Ferritin B12 & Folate | ESR | | LFT | CRP | INR | | TFT | Lipids | Other – specify: | | PSA | Glucose Fasting |   **PRIORITY: ROUTINE  URGENT  fasting**  **If ongoing tests required please specify:**  **Duration/Up to:**  **Frequency:**  **Where to deliver bloods to? RFH  BGH** | | | | | | **Home Intermediate Care Therapy Services:**  Physiotherapy Rehabilitation and support for mobility or with managing activities of daily living  Occupational Therapy Rehabilitation and support for mobility or with managing activities of daily living  Both Physio and Occupational Therapy Rehabilitation and support for mobility or with activities of daily living | | | | | |
| **Falls support service:**  Falls risk assessment  Falls activity classes to promote strength/ balance  Falls education sessions  Fall medical assessment | | | | | |
| **Early Stroke Discharge support service:**  Date of stroke (must be within last 6 weeks):  Ongoing community support/rehabilitation following hospitalisation | | | | | |
| **Swallowing & Communication support:**  Has patient choked (total airway obstruction) YesNo  Coughing during eating and drinking? Yes  No  Chest infection in last 6 months? Yes  No  Is patient on a Risk Feeding protocol? Yes  No  Can raise alarm in an emergency? Yes  No | | | | | | **Complex Care Case Management service (multidisciplinary team case management):**  Case management for vulnerable patients with complex health needs | | | | | |
| **REFERRER NAME & DESIGNATION**: | | | | | | **REFERRER ORGANISATION, WARD & ADDRESS:** | | | | | |
| **REFERRER CONTACT NUMBER**:  **REFERRER EMAIL:** | | | | | | **REFERRAL DATE**: | | | | | |