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| --- | --- | --- | --- |
| **Patient Details** | | Referral date & time |  |
| Title | Mr  Mrs  Miss  Ms  Dr  Other | Surname |  |
| NHS No |  | First name |  |
| D.O.B. |  | Gender | Male  Female |
| Address |  | Tel no. |  |
| Post code |  | Next of Kin name & tel no |  |
| First language |  | Is patient aware of referral and consented? | Yes  No |
| Interpreter required? | Yes  No | Is patient housebound? | Yes  No |
| Does the patient consent to sharing their relevant electronic GP records and data with the Community Team? | | | Yes  No |

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| **Service Required (For Stroke Early Supported Discharge please phone 07747461273)** | |
| Community Nursing Service  Community Rehabilitation Physiotherapy  Community Rehabilitation OT  Community Rehabilitation Speech  Rapid Response Admission Avoidance  Complex Care (Frailty) Pathway  Heart Failure Nursing Service  Community Phlebotomy Service | Stroke & Neuro Physiotherapy  Stroke & Neuro OT  Stroke & Neuro Speech  Stroke & Neuro Psychology  COPD Pulmonary Rehabilitation  Home Oxygen Service  COPD Respiratory Clinic  COPD Self-Management/Domicilary Visit  COPD Smoking Cessation |

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| **Urgency (Important: Referrals for same/next day appointments need to be received by 4pm Mon-Fri. For urgent appointments outside these hours please phone 020 3317 3400)** |
| Is the patient at risk of immediate hospital admission?  Yes  No  Is the patient in need of immediate medical input?  Yes  No |

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| **Referral Reason (Please note that referrals for major adaptations, housing and care packages should be sent to Camden Access & Support Team - Tel: 020 7974 4000)** |
| Please state client’s rehabilitation goals (if applicable):  Is this a new problem?  Yes  No  If the answer is “No” how long have they had this problem?  Has there been a recent change in the patient’s baseline function?  Yes  No  If “Yes” please give details: |

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| **Falls (Please complete if client has been experiencing falls)** |
| Has the client had any falls in the last 6 months?  Yes  No  Unknown  Please state the number of falls the client has had in the last 6 months:  When & where was the client's last fall?  Has the client had their falls medically investigated?  Yes  No (if Yes, please provide details) |

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| **GP details** | | | |
| Practice |  | GP name |  |
| Tel no. |  | E-mail address |  |

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| --- | --- | --- | --- |
| **Referrer details** | | | |
| Referrer is GP? | Yes  No  If yes, skip this section. | Referrer name |  |
| Relationship to patient |  | Tel no |  |
| Fax no |  | Email |  |

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| **Medical history** | |
| Medical History attached | GP: template populated with history. |
| **Medications (please list):** | **Allergies (please list):** |
| **Smoking Status** | |
| Current Smoker  Previous Smoker  Never Smoked | |

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| **Diagnosis (Please complete if patient has a diagnosis affecting their current function)** |
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| Risk assessment |
| **Are there any known risks?**  Are there other people/pets living in the client’s home that could cause a risk?  Yes  No  Are there any known risks associated with the property?  Yes  No  Do the areas around the property have adequate lighting & clear/safe access?  Yes  No  Can client provide access to the property? (if not give details)  Yes  No  Does client have a history of mental health illness, mood swings  or face high levels of stress?  Yes  No  Does client have problems with violence, drug or alcohol abuse?  Yes  No |

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| **Other Services Involved (i.e. Adult Social Care)** |
|  |

**IN ORDER TO AVOID ANY UNNECESSARY DELAYS PLEASE ENSURE THAT ALL SECTIONS OF THE FORM HAVE BEEN FULLY COMPLETED.**

**Once complete please email the form to:** [**camdenreferrals.cnwl@nhs.net**](mailto:camdenreferrals.cnwl@nhs.net)

**Please only email your referral form using an officially accredited secure account (e.g. *nhs.net* or *cjsm.net*). If you would like advice on this please feel free to contact Central Access on 020 3317 3400.**

**IF REFERRING TO PHLEBOTOMY, HEART FAILURE OR RESPIRATORY SERVICES PLEASE FILL IN RELEVANT ADDITIONAL SECTION BELOW**

**HEART FAILURE & RESPIRATORY (COPD)**

|  |  |
| --- | --- |
| **When was diagnosis made?** |  |
| **Where was diagnosis made?** |  |
| **Secondary Care Consultant** |  |
| **Site** |  |
| **Date and site of last echo (Heart Failure only)** |  |
| **For respiratory referrals, please include the latest spirometry results below. Please note that failure to provide this information will delay the referral.** | |
| **Date of last Spirometry** |  |
| **FEV1: (Litres Value)** |  |
| **FEV1: (% Predicted)** |  |
| **FVC: (litres Value)** |  |
| **FVC (% Predicted)** |  |
| **FEV1/FVC Ratio** |  |

**------------------------------------------------------------------------------------------------------**

**PHLEBOTOMY**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  | NHS Number |  |
| D.O.B. |  | GP Name & Practice |  |

**Lab bloods should be sent to:** UCLH  RFH

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| --- | --- | --- | --- | --- | --- | --- |
| **Bloods to be taken:**  Fasting **Reason for blood test:** | | | | | | |
| **BIOCHEMISTRY** | | **HAEMATOLOGY** | | | **VIROLOGY** | |
| **Gold**  Renal (Na/K/Cret/Urea)  LFT  Gamma GT  Bone Profile  Cholesterol  Lipids  Urate  PSA  Thyroid Function  CRP  Iron  Other (please specify): |  | **Purple**  FBC and Differential  ESR  Monospot  Sickle Screen  Hb Electrophoresis  Other (please specify): |  | | **Red**  Other (please specify): |  |
| **Gold**  Red Cell Folate/Serum B12  Other (please specify): |  | |
| **IMMUNOLOGY** | |
| **Blue**  Prothrombin Time/INR  Coagulation Screen  Other (please specify): |  | | **Red**  ANA  Rheumatoid Factors  Autoantibodies  Other (please specify): |  |
| **Grey**  Glucose  Other (please specify): |  | **THERAPEUTIC DRUG MONITORING** | | |
| **Red**  Drug  Dose  Time of last dose  Other (please specify): | |  |
| **Purple**  HbA1c  Other (please specify): |  |

Lab bloods should be sent to: UCLH  RFH

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| --- | --- | --- |
| **Urgency** | | |
| Urgent | Routine | Comments: |

**\*\*\*\*\*\*\*\*NB: REFERRAL MUST BE RECEIVED BEFORE 14:00 IF YOU WISH FOR THE PATIENT TO BE SEEN THE NEXT WORKING DAY\*\*\*\*\*\*\*\***