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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 [ ]  NoIs 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 [ ]  NoIf the answer is “No” how long have they had this problem?Has there been a recent change in the patient’s baseline function? [ ]  Yes [ ]  NoIf “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 [ ]  UnknownPlease 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 [ ]  NoIf 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 [ ]  NoAre there any known risks associated with the property? [ ]  Yes [ ]  NoDo the areas around the property have adequate lighting & clear/safe access? [ ]  Yes [ ]  NoCan client provide access to the property? (if not give details) [ ]  Yes [ ]  NoDoes client have a history of mental health illness, mood swings or face high levels of stress? [ ]  Yes [ ]  NoDoes client have problems with violence, drug or alcohol abuse? [ ]  Yes [ ]  No |

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

**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)**

|  |  |
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| **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**

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| 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) LFTGamma GTBone ProfileCholesterolLipidsUratePSAThyroid FunctionCRPIronOther (please specify): | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | **Purple** FBC and DifferentialESRMonospotSickle ScreenHb ElectrophoresisOther (please specify): |  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  | **Red** Other (please specify): | [ ]  |
| **Gold**Red Cell Folate/Serum B12Other (please specify): |  [ ]  [ ]  |
| **IMMUNOLOGY** |
| **Blue**Prothrombin Time/INRCoagulation ScreenOther (please specify): |  [ ]  [ ]   [ ]   | **Red**ANARheumatoid FactorsAutoantibodiesOther (please specify):  | [ ]  [ ] [ ]  |
| **Grey**GlucoseOther (please specify): | [ ] [ ]  | **THERAPEUTIC DRUG MONITORING** |
| **Red** DrugDoseTime of last doseOther (please specify): | [ ] [ ]  [ ] [ ]  |
| **Purple** HbA1cOther (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\*\*\*\*\*\*\*\***