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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:** Yes **[ ]** No **[ ]  Assistance of 1:** Yes **[ ]** No **[ ]  Able to do stairs:** Yes**[ ]** No **[ ]**  |
| **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 & siteSuture/clip removal **[ ]** Continence assessment **[ ]** Bowel care **[ ]** Catheter care **[ ]** Pressure area care **[ ]** Equipment provision **[ ]** Flu vaccination **[ ]** **Home Phlebotomy service** **(house-bound only):**

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| 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) Yes**[ ]** No **[ ]** 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**: |

**EMAIL FULLY COMPLETED FORM TO**:

* **Planned Care referrals email**:clcht.plannedcarebarnet@nhs.net
* **Unplanned Care referrals email**:clcht.unplannedcarebarnet@nhs.net

To speak with a Community Team member please call: Tel: **0300 020 0655**