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| **Tower Hamlets Community Health Services Referral Form** |
| Please e-mail this referral form back to: [thgpcg.spa@nhs.net](mailto:thgpcg.spa@nhs.net)  **Telephone No**: 0300 033 5000 |

Please complete initial referral section and corresponding numbered section

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| **Service(s) Required** | | | |
| **1.** | **Rapid Response Team** | **6.** | **Nurse-led Community Heart Failure Team** |
| **2.** | **Continence Service** | **7.** | **Community Diabetes Service** |
| **3.** | **Extended Primary Care Teams (EPCTs)** | **8.** | **Adult Respiratory and Rehabilitation Care Service (ARCaRe)** |
| **4.** | **Foot Health Service** | **9.** | **Community Dietetics Service** |
| **5.** | **Lower Limb / Leg ulcer management** | **10.** | **THCNT - Community Neuro Team including Community Speech and Language Service** |

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| **Patient Details** | | | | | | | | | | | | | | | | | | | | | | |
| **Full Name (Inc. Title)** | |  | | | | | | | | | **Telephone No.** | | | | | |  | | | | | |
| **NHS Number:** | |  | | | | | | | | | **Mobile No.** | | | | | |  | | | | | |
| **Date of Birth** | |  | | | | | | | | | **E-mail Address** | | | | | |  | | | | | |
| **Address** | | | | | | | | | | | | | | | | | | | | | | |
| **Full Address** |  | | | | | | | | | | | | | | | | | | | | | |
| **Postcode** |  | | | | | | | | | | **Key Safe Location** | | | | | | | |  | | | |
| **Key Safe No.** |  | | | | | | | | | |
| **Temporary Address** | | | | | | | | | | | | | | | | | | | | | | |
| **Full Address:** |  | | | | | | | | | | | | | | | | | | | | | |
| **Postcode** |  | | | | | | | | | | **Key Safe Location** | | | | | | | |  | | | |
| **Key Safe No.** |  | | | | | | | | | |
| **Language & Ethnicity** | | | | | | | | | | | | | | | | | | | | | | |
| **Main Spoken Language** | | | |  | | | | | | | | **Interpreter required?** | | | | | | | | | **No Yes** | |
| **Ethnicity** | | | |  | | | | | | | |  | | | | | | | | |  | |
| **Impairments to service access** | | | | | | | | | | | | | | | | | | | | | | |
| **Physical/Communication impairments, especially if requires assistance with arranging appointments?** | | | | | | | | | No Yes – Details: | | | | | | | | | | | | | |
| **Does patient require transport to attend appointment?** | | | | | | | | | No Yes – Details: | | | | | | | | | | | | | |
| **Next of Kin / Carer Details** | | | | | | | | | | | | | | | | | | | | | | |
| **Full Name** | | |  | | | | | | **Relationship to patient** | | | | | | | | | | |  | | |
| **Telephone No.** | | |  | | | | | | **Availability** | | | | | | | | | | |  | | |
| **Mobile No.** | | |  | | | | | | **Care Package / Agency** | | | | | | | | | | |  | | |
| **Availability** | | |  | | | | | | **E-mail Address** | | | | | | | | | | |  | | |
| **GP Details** | | | | | | | | | | | | | | | | | | | | | | |
| **Named GP** | | |  | | | | | | **GP Practice Name** | | | | | | | | |  | | | | |
| **Telephone No** | | |  | | | | | | **Address** | | | | |  | | | | | | | | |
| **E-mail Address** | | |  | | | | | |
| **Referral Details** | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Date** | | |  | | | | | | **Referrer Name** | | | | | | |  | | | | | | |
| **Organisation** | | |  | | | | | | **Telephone No.** | | | | | | |  | | | | | | |
| **Email Address** | | |  | | | | | | **Role** | | | | | | |  | | | | | | |
| **Referral Consent** | | | | | | | | | | | | | | | | | | | | | | |
| **Patient consented to referral?** | | Yes  No | | | | | **Patient informed of information sharing?** | | | | | | | | | | | | | | | Yes  No |
| **Risk Assessment** | | | | | | | | | | | | | | | | | | | | | | |
| **Living Circumstances** | | | | | Alone | | | With family / friends | | | | | | | Other  : | | | | | | | |
| **Housebound** | | | | | Yes  No | | | | | | | | | |  | | | | | | | |
| **Able to open door** | | | | | Yes  No  **Details of contact person to arrange access**: | | | | | | | | | | | | | | | | | |
| **Environmental Risk(s)** | | | | | *(Lone Worker risks, inadequate lighting in area, secluded location, pets***)**  **Details:** | | | | | | | | | | | | | | | | | |
| **Previous or current experience of mental health issues?** | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **Previous or current suicidal ideation/ attempt/ self-harm?** | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **Known to Mental Health Services?** | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **History of violence/aggression towards others?** | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **Current expressions of violence/ aggression /threatening behaviour?**  (*either by patient or others living at the same address*) | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **Communication Difficulties** | | | | | | | | | | | | | **No  Yes  - Details:** | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | |
| **Services will refer to the EMIS Shared Record.** | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Reason(s) for Referral(s)\*\*:** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Hospital Discharge Referral** | | | | | | | | | | | | | | | | | | | | | | |
| **Planned Discharge Date**  *(if this changes Single Point of Access* ***Must*** *be Informed)* | | | | | |  | | | | **Discharging Ward** | | | | | | | | | |  | | |
| **Telephone No** | | | | | | | | | |  | | |
| **Visit required on** *(date of intervention)* | | | | | | | | | |  | | | | | | | | | | | | |
| |  | | --- | | Please fill out **All** criteria for each service that you are referring the patient for. | | | | | | | | | | | | | | | | | | | | | | | |

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| 1. **Rapid Response Team** | | | | | |
| **Rapid Response (within 2 hours)** Imminent risk of hospital admission and patient is in crisis requiring urgent interventions | | | | | |
|  | **Nursing** |  | **Occupational Therapy** |  | **Physio** |

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| 1. **Continence Service** | |
|  | **I confirm the patient is free from constipation and urine infection** |

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| 1. **Extended Primary Care Teams (EPCT)** | | | | |
|  | **24 hour response** - Patient at risk of hospital admission, walking assessment or functional rehabilitation including mobility aid requirement, patient at risk of falls or pressure sores. | | | |
|  | **Standard Referral –** 48 hour response. Palliative care, complex case management, rehabilitation to gain personal goals, medicines management and education for independent living**.** | | | |
|  | **2-5 days** - Longer term rehabilitation and exercise programmes, routine post-surgical follow-up, swallowing difficulties, communication problems, cognitive and vocational rehabilitation, psychological distress, manual handling issues, continence assessment | | | |
|  | **District Nursing Housebound patient only** |  | **Care Navigator** | |
|  | **Occupational Therapy** |  | **Physiotherapy** | |
|  | **Integrated Care Social Worker** |  | **Integrated Care Mental Health Liaison Nurse** | |
| **Medication Administration** | | | | |
| **Does this patient require Medication Administration?** | | | | **No  Yes** |
| **Is medication available in the home? No  Yes  (please read below)**  ***If Yes, please provide a copy of the TTA if the patient is on the ward. For community referrals, if patient does not have shared record, please attach list of medications(s). For Palliative Care Medications requiring administration via a syringe pump, please complete and attach the Syringe Pump Authorisation Chart.*** | | | | |

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| 1. **Foot Health Service** | | | |
|  | **High Risk;** Diabetes |  | **Previous Ulceration** |
|  | **PAD/PVD** |  | **Neuropathy** |
|  | **Rheumatoid Arthritis** |  | **Nail Surgery (IGTN)** |
|  | **Other** (*please state*)**:** |  |  |
|  | Requires assessment for **Congenital Foot Deformity:** Footwear  ***\*Please note - we do not provide in shoe orthotics***  ***For further information regarding inclusion/exclusion criteria please click here***  [***http://gp.towerhamletsccg.nhs.uk/clinical-services/Musculoskeletal/foot-health-and-podiatry.htm***](http://gp.towerhamletsccg.nhs.uk/clinical-services/Musculoskeletal/foot-health-and-podiatry.htm) | | |
| **Home visit required? No  Yes**  Please note a GP is required to authorise this service as **house calls can only be provided to those who are entirely bedbound.** | | | |

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| 1. **Lower Limb / Leg Ulcer Management** | | | |
| **Patients must have had a non-healing lower limb wound for 6 weeks or more for leg ulcer management.** | | | |
|  | Lower Limb |  | Leg ulcer management |
|  | Date of Last Doppler | Last ABPI Measurement = | |

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| 1. **Nurse-Led Community Heart Failure Service** | | | | |
| **Patient MUST have a Diagnosis of Heart Failure confirmed by Echo or other diagnostic testing –** *If not, please refer to diagnostic pathway rather than to this service.* | | | | |
|  | **URGENT (72 hours)** – Patient’s in an exacerbation of heart failure and at risk of hospitalisation | | | |
|  | **Routine (2 weeks)** – Recent hospital admission / discharge with primary diagnosis of heart failure. **No  Yes**  In need of specific heart failure palliative care management if required. **No  Yes** | | | |
|  | **Non-Urgent (6 weeks) -** Stable patients requiring titration of evidence based medication as per NICE guidance (2010) for HFrEF. . **No  Yes**  Patients requiring education and guidance with self-management strategies.  **No  Yes** | | | |
| **Clinical Details** | | | | |
| **Level of Oedema:** | |  | **ECG** |  |
| **Blood Pressure** | |  | **eGFR** |  |
| **Latest Blood Pressure** | |  | **Weight** |  |
| **Known to other MDT?** | | **No  Yes**  - **Details:** | | |

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| 1. **Community Diabetes Service** | | | | | | | | | | | | |
| ***\*Please check referral guidance before referring to this service, as incorrect referrals may delay care. –***[***http://gp.towerhamletsccg.nhs.uk/diabetes.htm***](http://gp.towerhamletsccg.nhs.uk/diabetes.htm) | | | | | | | | | | | | |
|  | | **Type of Diabetes: Type 1**  **Type 2  Other:** | | | | | | | | | | |
| **Diabetes Specialist Nurse** (*Please tick reason(s) below)* | | | | | | | | | | | | |
|  | | **URGENT (72 hours)** -Recent A&E attendance or hospital admission due to Hypoglycaemia, Diabetic Ketoacidosis (DKA) or Hyperosmolar Hyperglycaemic State (HHS)  Insulin or non-insulin injectable diabetes medication started in hospital | | | | | | | | | | |
|  | | **Non – Urgent (4 - 6 Weeks) –** please see referral guidance | | | | | | | | | | |
|  | | For Insulin initiation | |  | For GLP-1 therapy initiation | | | | |  | | Hypoglycaemia |
|  | | Optimisation of glycaemic control (patients on insulin or GLP-1) | | | | | | | | | | |
|  | | Pre-conception diabetes management | | | |  | Patient new to practice and on insulin pump therapy | | | | | |
|  | | **Clinical Psychologist for people living with Diabetes** | | | | | |  | **Diabetes Specialist Dietitian** | | | |
| **Diabetes Education** | | | | | | | | | | | | |
| ***Diabetes education is available in Bengali and English – please state patient preference in Language section of referral (please see referral guidance)*** | | | | | | | | | | | | |
| **Latest HbA1C reading** | | |  | | | | **Date of HbA1C reading** | | | |  | |
|  | **Pre - Diabetes** *(HbA1C 42-47 mmol/mol)* | | | | | | | | | | | |
|  | **XPERT** *(Type 2 – HbA1C > = 48mmol/mol)* | | | | | | | | | | | |

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| 1. **Adult Respiratory Care and Rehabilitation Service (ARCaRe)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) to ARCaRe (within 24hrs)  **Call triage phone on :** **07983177719** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pulmonary Rehabilitation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***\*Please Note*** ***that referrals will be automatically rejected unless the inclusion and exclusion criteria have been considered*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Exclusion Criteria (*patient does not have any of the following*)**: Unstable angina/hypertension, Angina more than once a week, Angina at rest/at night, Uncontrolled cardiac arrhythmias, Severe heart failure, Cardiac event within the past 6 weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Inclusion Criteria (*patient has any of the following*)**: Stable Chronic Lung Disease, Limited functional ability due to breathlessness, Motivated to exercise, Optimised respiratory Medical Management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Spirometry Results | | | | | | | | | | | | | | | | | | | MRC\* | | | |  | | | | | | | | |
| Pre | | | |  | | | Post | |  | | Predicted | | | | | |  | | SpO2 | | | |  | | | Room air/ | | | | |  |
| FEV**1** | | | | |  | | | | | VC | | | | |  | | | | ABGS Date: | | | |  | | | Room air/ | | | | | O2 |
| FEV1/VC% | | | | | | |  | | | | | | | | | | | | pH | | | |  | | | PCO2- | | | | |  |
| **Chronic Heart Failure Rehabilitation (**provided by ARCaRe) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Exclusion Criteria (*patient does not have any of the following*):** Unstable angina/hypertension, Recent Embolism/hypertension, Critical ischaemia, Poorly controlled diabetes, Unstable cardiac conditions, Recent ICD | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Confirmed Diagnosis of Chronic Stable Heart Failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Mobility and function limited by Heart Failure | | | | | | | | | | | | | | | | | | | | |  | | Motivated by exercise | | | | | | |
| **NYHA Class** | | | | | | | | | | | | | | | | | | | **Risk Factors** | | | | | | | | | | | | |
| LV Function | | | | | | | | Mild Moderate  Severe | | | | | | | | | | |  | | Hypertension | | | | | | |  | | Diabetes | |
| Arrhythmias | | | | | | | | Yes  No | | | | | | | | | | |  | | Smoking | | | | | | |  | | High BMI | |
| Angina | | | | | | | | Yes  No | | | | | | | | | | |  | | Hypercholesterolemia | | | | | | |  | | Family History | |
| ICD | | | | | | | | Yes  No | | | | | | | | | | | Sedentary Lifestyle | | | | | | | | | | | | |
| PPM: | | | | | | | | Yes  No | | | | | | | | | | |
| Type: | | | | | | | |  | | | | | | | | | | |
| **Spirometry Clinic** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for referral to Spirometry Clinic: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Initial Diagnosis | | | | | |  | | Review | | | | Current Smoking Status : | | | | | | | | | | | | | | |
|  | | | | | | Asthma | | | | | |  | | COPD | | | |  | | SOB | |  | | Cough | | | Other: | | | | | |
| **Infection Risk** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | None | | | | | | |  | | | Active TB | | | | | |  | | MRSA | | |  | | Recent Chest Infection | | | |
|  | | | | | | Immunocompromised | | | | | | |  | | | Other: | | | | | | | | | | | | | | | | |
| **Inhaler Medication** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Inhalers Used? | | | | | | | **No  Yes**  - **Details:** | | | | | | | | | | | | | | | | | | | |

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| 1. **Community Dietetics Service** | | | |
| ***\*Please note that all referrals for nutrition support (patients who are undernourished and/ or underweight) must be accompanied by a screening tool score. Referrals without a score cannot be accepted.*** | | | |
| **Malnutrition Universal Screening Tool Scores** | | | |
| **Current Weight** | Kg | **Weight Loss History (3-6 months)** | Kg |
| **BMI** | Kg/m2 | **MUST Score** |  |
| **Patient has Pressure sore?** | | **No  Yes  - Grade:** | |
| **Is this a Home Enteral fed Patient?** | | **No  Yes**  - **Details:**  ***(\*please contact Community Dietitians for further information on*** [***BHNT.THdietitians@nhs.net***](mailto:BHNT.THdietitians@nhs.net) | |

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| 1. **Community Neuro Team including Community Speech and Language Therapy Services (THCNT)** | | | | | | |
|  | **Physiotherapy** | | |  | **Clinical Psychologist** | |
|  | **Occupational Therapy** | | |  | **Clinical Nurse Specialist** | |
| **Response requirement Triage:** | | | **(*Please Note: this is not a rapid response service*)** | | | |
| ***\*Routine assessment occurs within 10 working days*** | | | | | | |
| **Is assessment required before 10 working days?** | | | | | | **No  Yes** |
| **Rationale for response requirement:** | | | |  | | |
| **Community Speech and Language Therapy Services** | | | | | | |
| **Response requirement Triage:** | | **(*Please Note: this is not a rapid response service*)** | | | | |
|  | **Risk to Chest health** | | | **No  Yes**  - **Details:** | | |
|  | **Recent chest infection** | | | **No  Yes**  - **Details:** | | |
|  | **Frequency of swallowing difficulty** | | | **No  Yes**  - **Details:** | | |
|  | **High level of distress by client / carer** | | | **No  Yes**  - **Details:** | | |