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| **SECTION 1 REFERRER DETAILS**  |
| Date of Admission:  | Ward: Phone no: |
| Name of referrer: | Designation: Bleep: |
| Date of referral: | Expected Discharge Date: |
| COVID STATUS on referral: +ve [ ]  -ve [ ]  Pending [ ]  Date of swab:  |
| **Pathway Identified (IDH use): Pathway 1** [ ]  **Pathway 2** [ ]  **Pathway 3** [ ]  |
| **SECTIONS 1-3 MANDATORY FOR ALL REFERRALS** |
| Discharge did not go ahead as planned? Needs unchanged Yes ☐ Needs changed - form has been updated Yes ☐  |
| **SECTION 2 SERVICE USER PERSONAL INFORMATION**  |
| Name:  | NHS number:  |
| Telephone number(s):  | Borough: |
| D.O.B:  | Gender:  |
| Address:   | Postcode: |
| Person to contact: | GP Name:  |
| Relationship e.g. neighbour:  | Address:  |
| Do they live with the referred person? Yes [ ]  No [ ] Has the person consented to information regarding discharge being shared with this person? Yes [ ]  No [ ]  | GP phone number:  |
| NOK Telephone number(s):  | Language(s): Interpreter required? Yes [ ]  No [ ]  |
| **SECTION 3 REASON FOR ADMISSION AND ONGOING MEDICAL NEEDS** |
| Reason for admission and current health concerns: | Follow up/out-patient appointment (s) if known: |
| Relevant medical history:   | Does patient have capacity to make decisions regarding their discharge? Yes [ ]  No [ ] Has patient been informed of discharge plan: Yes [ ]  No [ ] Has consent for onward referral been obtained? Yes [ ]  No [ ] If no to the above, why not?Is an IMCA required? Yes [ ]  No [ ]  Unknown [ ]  |
| Is the patient retuning to a Nursing Home? Yes ☐ No ☐ | If Yes, complete sections 1-3 and send to IDH |
| **SECTION 4 COMMUNITY HEALTH SERVICES REQUIRED** |
| District Nursing [ ]  Physiotherapy ☐ Clinical Psychology [ ]  Dietitian ☐  | Occupational Therapy [ ]  Continence Services [ ]  Speech & Language [ ]  | Team referral is for if known:Community Neuro team ☐AADS OT/PT ☐EPCT OT/PT ☐ |
| Nursing/Therapy Response time: Same day [ ]  24 Hours [ ]  48 Hours [ ]  72 Hours [ ]  7 days or longer [ ]  N.B. Specialist teams have different response times. |
| Therapy goals: |
| **SECTION 5 SOCIAL HISTORY AND ENVIRONMENT (NON NURSING)** |
| Living Circumstances: Is there a key safe? Housebound?Able to open door? Details of contact person to arrange access: | Alone [ ]  With family / friends [ ] Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ]  | Environmental Risk(s) if known (Lone Worker risks e.g. pets) Details: |
|  | Previous Function | Current Function: |
| Mobility *(AO1, AO2, any restrictions eg. WB status):*Transfer:Personal care:Domestic tasks:Community tasks:Cognition: |  |  |
| Equipment required for discharge: (that needs to be ordered by the IDH) |
| **SECTION 6 CARE SUPPORT NEEDS (SOCIAL WORK / STEP DOWN BED REFERRAL)** |
| **Request for review of previous care package (MDT must confirm no change in function since admission/ED attendance) Yes ☐** |
| New package of Care required: Yes [ ]  No [ ] Has consent been provided by patient for social care intervention? Yes [ ]  No [ ] If no and patient lacks capacity to make this decision, has a best interest decision been made? If yes, then please refer. |
| Care support currently provided on the ward:Medication (prompting) [ ]  Transfers [ ]  Personal care [ ]  Toileting [ ]  Brief description of care support required:AM ☐ LUNCH ☐ PM ☐ EVENING ☐ Single Handed ☐ Double handed ☐N.B. Add suggested length and time of visits above or state not known/no preference expressed ☐   |
| Accommodation: Does patient have a safe place to go on discharge? Yes [ ]  No [ ] If no, briefly state issues patient has raised:Is a step down bed required? Yes ☐ No ☐ (See step down bed eligibility criteria) |
| **SECTION 6A COMPLEX CARE**  |
| Likely to be eligible for CHC Yes ☐ No ☐Provide reasons for more care support than generic package e.g. night care being required:High risk of falls without family member who can supervise safely Yes [ ]  No [ ] Bed dependent Yes [ ]  No [ ] Unsteady gait or attempts to climb out or bed or get out of chair unaided Yes [ ]  No [ ] Pressure ulcer category 3 and above requiring repositioning during the night Yes [ ]  No [ ] *N.B. If yes to category 3 pressure ulcer, ensure further details are provided in Section 5, Nursing needs*Is patient at the End of Life? Yes ☐ No ☐ If Yes, is there a DNAR in place in hospital? Yes ☐ No ☐ |
| **SECTION 7 NURSING & SPECIALIST TEAM REFERRAL – ATTACH ADDITIONAL INFORMATION AS RELEVANT e.g. FOR ANY TISSUE VIABILITY, CONTINENCE, WOUND CARE NEEDS** |
| Reason for referral: |
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| Hospital Bed requiredUrine bottle:Pressure Mattress or cushion: | YesYesYes  | [ ] [ ] [ ]  | NoNoNo  | [ ] [ ] [ ]  |  |  |  |

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| Wound care : Traumatic [ ]  Surgical wound [ ]  Other: Dressings supplied Yes [ ]  Date of last dressing change:  |
| Medication: Needs support for medication Yes [ ]  No [ ]  Medication via PEG [ ] Requires support with Insulin Administration Yes [ ]  No [ ]  Time required\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tinzaparin Injections - Date/Time last injection given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IV Antibiotic Therapy: *N.B. Call In-reach for TH residents; other boroughs may require own paperwork to be completed.* N*o more than twice a day IVABs accepted for Newham residents* |
| Continence:Continent of urine Yes [ ]  No [ ]  Continent of faeces Yes [ ]  No [ ]  Catheter in situ Yes [ ]  No [ ]  Size:………….. Date inserted:…………………….. Urethral [ ]  Suprapubic [ ]  Pads provided if needed Yes [ ]  No [ ]  Has a continence assessment been completed on the ward? Yes [ ]  No [ ]  Other details regarding management of continence:  |
| Any concerns re skin integrity? Yes [ ]  No [ ]  If yes, provide details (e.g. pressure area concerns, continence, wounds): |
| Palliative Care/End of Life Care needs: Yes [ ]  No [ ]  Anticipatory medicines will be provided on discharge: Yes [ ]  No [ ]   (Consider completing Fast Track documentation if rapidly deteriorating) |
| Any current, unmanaged pain? Yes [ ]  No [ ]  Details: |
| Breathing/respiratory issues: (e.g. NIV in situ, tracheostomy, oral suctioning) Yes [ ]  No [ ]  Details: |
| Nutrition (swallow concerns, modified diet, enteral feeding, supplements): Yes [ ]  No [ ]  Details: |

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| **SECTION 8 RISK ASSESSMENT AND IMMEDIATE NEEDS FOR DISCHARGE (IDH TO COMPLETE MISSING INFORMATION)** |
| Safeguarding ConcernsPrevious or current experience of mental health issues? | Yes ☐ No ☐ Details:Yes [ ]  No [ ]  Details: |
| Previous or current suicidal ideation/ attempt/ self-harm? | Yes [ ]  No [ ]  Details: |
| Known to Mental Health Services? | Yes [ ]  No [ ]  Details: |
| History of violence/aggression towards others? | Yes [ ]  No [ ]  Details: |
| Current expressions of violence/ aggression /threatening behaviour?(*either by patient or others living at the same address*) | Yes [ ]  No [ ]  Details: |
|  |  |
| Any other information? |  |

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