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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: | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Hospital Bed required  Urine bottle:  Pressure Mattress or cushion: | Yes  Yes  Yes |  | No  No  No |  |  |  |  | | | | | | | |
| 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 Concerns  Previous 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? | |  | |