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| **Telephone Referral** |

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| **Referrer Details** |
| Has the person given their consent to this referral and the sharing of information with other professionals and agencies? Yes [ ]  No [ ]  Do they have capacity? Yes [ ]  No [ ]   |
| Referrer Name |   | Job Title |  |
| Tel Number |  | Ward Details |  |
| **Patient Details** |
| **Title:**  | Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other [ ]  | **RAG:** |
| **Name:** |  | **Preferred name:** |  |
| **DOB:**  |  | **Gender:** |  |
| **Address** [**[Must reside in catchment area, check guide if unsure]**](https://www.nhs.uk/Services/Trusts/GPs/DefaultView.aspx?id=89686) |  | **Postcode:** [**[carry out google maps check]:**](https://www.google.com/maps/%4051.8805493%2C0.8995728%2C14z) |
| **Contact Number:** |  | **Additional Number:** |  |
| **NOK Name:** |  | **NOK Number:** |  |
| **Emergency Contact NameName:** |  | **Number:** |  |
| **Customer lives with:** |  |
| **Language Preference:** |  | **Religion:**  |  |
| **Access details:** |  | **Key safe No:** |  |
| **Expected Date & time to arrive home: -**  |
| **Hospital Transport Yes** [ ]  Other [ ]  Already at home [ ]   |
| **Has customer been assigned to a Social Worker: Yes** [ ]  No [ ]  **If so name and number?**  |
| **GP and Ongoing Care Arrangements** |
| GP Surgery |  | Tel. No.  |
| **Is there a care package already in place?** Yes [ ]  No [ ]  |
| If **yes,** please provide the name of the agency:  | **Tel. No.**  |
| **Does the person need ongoing care or reablement?** Yes [ ]  No [ ] **Has the customer been referred to ECL/ARC ?**  Yes [ ]  No [ ] **Has the customer been referred to ASC ?** Yes [ ]  No [ ]  | **Start date of service:**  |
| **Type of referral****Pop/Brace** [ ]  **UCRS** [ ]  **TOCH** [ ]  **Homeward** [ ]  **Night owls** [ ]  **Night sit** [ ]   |
| **Current Crisis Information** |
| **Reason for referring:** |
| **Required Service Input**  |
| **Visits required: AM** [ ]   **LUNCH**  [ ]  **TEA** [ ]  **PM** [ ]   **How many carers will be needed to assist the service user?** One [ ]  Two [ ] **What is required from carers?** **A little bit about me;**

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| **Administration of medication:** | **Fully Independent** [ ]  | **Prompting required** [ ]  | **Assistance required** [ ]  |
| **Medication in:** | **Blister Pack** Yes [ ]   | **Original boxes** Yes [ ]   |  |
| **Oxygen (COSHH assessment)** Yes [ ]  | **Nebuliser & Inhalers** [ ]  | **Eye/Ear drops** Yes [ ]  | **Stoma**  Yes [ ]  **Catheter** Yes [ ]   |

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| **Provide any known risks to customer or in property where they live:** | Yes [ ]  No [ ]  **Details:** |
| **Any pets in the property:** **Are there any registered assistance dogs in the property?** | Yes [ ]  No [ ]  **Details:**Yes [ ]  No [ ]  **Details:** |
| **Safeguarding Concerns:** | Yes [ ]  No [ ]  **Details:****Are Adult Social Care Aware:** Yes [ ]  No [ ]   |
| **CUSTOMER WEIGHT BEARING STATUS AND EQUIPMENT** |
|   **Equipment details**  |
| **Weight Bearing** | FWB Yes [ ]   | **Notes:** |
| **Weight Bearing** | PWB Yes [ ]   | Frame Yes [ ]  Sara Steady Yes [ ]  Rotunda Yes [ ]  OtherYes [ ]   |
| **Weight Bearing**  | NWB Yes [ ]   | Bed Care Yes [ ]  Hoist Yes [ ]  Slide sheet [ ]  Bedrails [ ]  (If yes, ask if DoLs in place) **Details:**  |
| **Mobility** **distance)** | Yes [ ]  No [ ]    | Frame [ ]  Stick [ ]  Walker [ ]  W/chair [ ]  Other [ ]  **Details:** |
| **Transfers** | Yes [ ]  No [ ]   | Hoist [ ]  Rotunda [ ]  Sara Steady [ ]  Return [ ]  **Details:** **Equipment in place:**   |
| **Kitchen Activities** | Yes [ ]  No [ ]   | Independent [ ]  +1 [ ]  +2 [ ]  family [ ]   |
| **Equipment assessed:** | Yes [ ]  No [ ]   | **Name:** Physio [ ]  O/T [ ]   |
| **Past Medical History & Current Medical Conditions** | **Medication being taken (please list medication if support requested) Known:** [ ]  **Unknown:** [ ]   |
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| **SENSORY AWARENESS & COMMENTS:** | **Visual impairment** [ ] **Wears glasses** [ ]  | **Hearing impairments** [ ] **Wears hearing aids** [ ]  |
| **Known allergies: (list allergies/outcomes if customer was to come into contact with)** |  |
| **Does this person have a known or suspected infection that can be passed to others?** |  | **Please state precautions to be taken:** |
| **Is the customer on the my care choices register?** |  Yes [ ]  No [ ]  | If **yes,** what are the resuscitation wishes? |
| **Is there a DNAR/RESPECT in place?** Yes [ ]  No [x]  |
| **Power of attorney in place?** | Yes [ ]  No [ ]   | Health [ ]  Financial [ ]  Both [ ]   |
| **Date and Time referral taken:** |  |
| **Date and Time discharge confirmed:** |  |
| **Referral taken by:** | **Name: Job Title:**  |