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Description automatically generated

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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/@51.8805493,0.8995728,14z) | | | | | |
| **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;**   |  |  |  |  | | --- | --- | --- | --- | | **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 | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **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:** | | | | | | | |
|  | | | | | | |  | | | | | | | |
| **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 | | | | | | | | |
| **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:** | | | | | | | | | | | |