Sussex Community NHS
NHS Foundation Trust

Brighton & Hove City Council

Brighton and Sussex University Hospitals NHS
NHS Trust

Ready to Transfer to SCFT Responsive Services

Patient Name:	**NHS/Hospital No:**	**Reason for Admission:**
DOB:	**Referring ward:**	**EOLC / FT / Neither**
Past Medical History:		

Package of care (POC) provided prior to hospital admission **YES / NO**

If yes, How many calls a day?..... Agency name.....

Has the POC been restarted for discharge? **YES / NO**

Current needs regarding mobility/transfer

Mobility Independent without aids? **YES / NO** *if with aids, state type:*

Zimmer frame	Wheeled Zimmer	Gutter frame	Walking stick	4 wheeled walker

Transfers

Independent	Assistance of x1	Assistance of x2	Use of hoist	Stand-aid

Current care support needs

Washing/dressing:

Independent	Assistance of x1	Assistance of x2

Eating/drinking:

Independent	Assistance of x1	Full support: PEG/ NG	Other (please state):

Toileting:

Independent	Commode	Urinal	Catheter	Incontinent
Please state support required, I.e. pads used/ assistance at night.....				

Night time support:

Independent	Urinal	Commode	Bedpan	Turning

Recommendations for future Care: .....

Current needs regarding emotional/mental health support

Alert/orientated:	Confusion/ disorientated:	Mild memory issues:	Any episodes of wandering during the day or night:	Diagnosis of mental health issues: (Dementia/ Alzheimer's/Bi polar)	Other issues:
Further information:					

Current needs regarding medication support

Prior to hospital admission was patient able to take own medication **YES / NO**

If no, please state who was providing support with this:.....

Is medicine supplied in **BOXES / BLISTER PACKS** Is medication taken **OD / BD / TDS / QDS**

Was patient on insulin prior to hospital admission **YES / NO** If yes, who was providing this support:.....

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Care or nursing issues

Current MUST score: ..... Wounds **YES / NO**

If Yes, please state type of wound and dressing required:.....

Are Pressure Areas Intact **YES / NO** If No, state category of damage:

1	2	3	4

Please state where damage is and current treatment: Pain management:

Current equipment requirements: (special mattress/bariatric equipment/commode)

Commode	Urinal	Hospital Bed	Pressure Mattress (type):	Other:	**Standard / Bariatric**

What you want Responsive Services to provide:

Any equipment	Is therapy dependent discharge	Use of Red Cross for support at home or transport	Access details to property i.e.: Key safe number	Social issues/isolation

If therapy is required on day of discharge, why?

Which other services has this patient been referred to? If IPCT, which cluster?.....

Referral advised for

A bed	Assessment at home	Short term support at home	H@H (nb SCFT do not provide care for H@H patients.

Any other information relevant to discharge (i.e. access to property/survival kit provided):
I agree that my information can be shared, on a need to know basis and in strict compliance with the law, with other people or organisations involved in my care: ***YES / YES with limitations / NO / No with limitations*** *Please list any person(s) you do not want to share this information with:*

Name:	Signature:	Date:	Time: