|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Name + Contact Details:** | Click here to enter text. | **Name of Ward:** | | | Click here to enter text. | | |
| **Date of Referral** | Click here to enter text. | **Time of Referral** | | | Click here to enter text. | | |
| **Patient Name:** | Click here to enter text. | |  | | |  | |
| **Patient Address:**  **Patient Telephone No:** Click here to enter text. | Click here to enter text. | | | **NoK Details:** Click here to enter text. | | | |
| **Key safe:** Yes  No  Contact details for key safe: Click here to enter text. | | | |
| **Patient DoB**  --------------------------  **NHS No**  -----------------------------------  **PMH:** | Click here to enter text.  ---------------------------------------------  Click here to enter text.  ---------------------------------------------  Click here to enter text.  --------------------------------------------- | | GP Practice: Click here to enter text.  Tel No: Click here to enter text. | | | | |
| **Date of Admission:** Click here to enter text.  **Very brief reason for admission**:  Click here to enter text. | | | Current NEWS2 Score Click here to enter text.  Click here to enter text. | | | | |
| **Covid-19 status if known/notification to self-isolate**  Click here to enter text. | | | | |
| **Brief description of health needs on discharge** – **Nursing**: wounds, catheter, injectables, **Therapy:**  Details:  Click here to enter text.  **CONFIRM PATIENT SAFE TO BE LEFT OVERNIGHT OR BETWEEN CARE CALLS**  Yes  (If no may need transfer to Bedded Unit) | | | | | | | |
| **Current Mobility and Transfers**  Able to Mobilise and Transfer Independently without aids.Yes  No  If no state type of aid : Click here to enter text.  Level of Assistance required if not Independent:  Supervision  Assistance of 1  Assistance of 2  Stand Aid  Full Sling Hoist  Other:  **Details:** Click here to enter text. | | | | | | | |
| **Care support needs on discharge**  Yes  No  Brief details of care support needed to support safe discharge (include medication support)  Click here to enter text.  **Please indicate whether single or double-up carers required**  Single  Double | | | | | | | |
| **Safety Checklist** | | | | | | | |
| Referrer has assessed patient transport needs and booked transport | | | | | | | Yes |
| Referrer has arranged for TTOs to be discharged with patient | | | | | | | Yes |
| **Discharge arrangements Agreed** | | | | | | | |
| Referral accepted | | Click here to enter text. | | | | | |
| Referral rejected Reason | | Click here to enter text. | | | | | |
| Referral waiting for care support provision | | Click here to enter text. | | | | | |
| Provisional Discharge date | | Click here to enter text. | | | | | |
| Agreed discharge date | | Click here to enter text. | | | | | |