|  |  |  |  |
| --- | --- | --- | --- |
| NHS numberPatient stickerPatient telephone number: | Referral date | MFFD | EDD |
| **Consent obtained for:-** Referral Yes No Share info Yes No  |
| **Lives alone**: Yes No If no who do they live with?**NOK/ emergency contact details:** Name:Relationship:Tel no: |
| GP practice name and tel no: | **Lasting Power of Attorney** **Health** Yes No **Finance** Yes No |
| **Reason for admission**: **Operation date:** | **Past Medical History**: include falls history & infection history**DNACPR** in place yes no  |
| **FAST TRACK:** does the patient have a rapidly deteriorating condition which may be entering a terminal phase? **Yes No****Details** | **DoLS: in place whilst in hospital?** **Yes No** Does patient have an allocated SW **Y N** **SW name:**  |
| **Current Infection prevention and control status****Covid-19 Status Not requiring testing**  **Tested negative no isolation**  **Positive and needs isolation**  **Tested- results not known**  | **Waterlow Score** | **MUST** |
| Is patient already known to **community nursing** Yes No Details of care: | **Nursing** needs on discharge? Yes No (clips, dressings, catheter, eye drops, insulin, medications etc.) Details:**Anticoagulant**: time, date ends: |
| **Is patient on INSULIN?** Yes No Frequency of dose: …………………………………………………………………Patient has own blood sugar monitor Yes No Community Nurses required for support with insulin  Yes No N/A  |
| **Medication:** |
| Can they self-administerYes No If no, who will support?  | Is medication in BLISTER PACKS? Yes No  |
| Numbers of time per day: OD BD TDS QDS  | MAR chart: Yes No Community prescription sheet: Yes No  |  **FAST TRACK patients:** anticipatory medications have been provided **Yes No**   |
| **Follow up appointments**: include dates and times of F/U appointments etc. fracture clinic | **TTO ready and with patient: Yes No**  PLAN |
| Patients name | DOB | NHS number |
| **Patient Goals** |
|   |
| **Safety Checklist for discharge** | Describe how patient will manage  |
| Patient is **physically** and **cognitively** safe to be left alone *BETWEEN* visits. Brief social history.Include how the patient will mobilise and transfer and any cognitive or communication issues. Does patient have pets? |  |
| **Continence** management (day and night) Plan |
| **Essential equipment** for discharge provided. Details: |
| **Key safe:** Yes No N /A Contact details for key safe: | **Pendant alarm** Yes No Other Telecare requested? |
| **Stairs: Internal Yes No N/A** **Access** to the patient’s home: steps etc. |   |
| **Night Time needs:** Independent Requires assistance details…………………………………………………………. |
| **Previous POC** Yes NoDoes patient have informal carers, e.g. family, neighbour, friend etc.? Yes No Details:Are they able to continue this level of care? Yes No  |
| **Size of Package of care needed on discharge:** None OD BD TDS QDS  |
| **POC required** |
| AM | Tick | Midday | Tick | PM | Tick |
| Enable wash & dress |  |  |  | Enable to get ready for bed |  |
| Empty commode |  | Empty commode |  | Empty commode |  |
| Supervise downstairs |  |  |  | Supervise up stairs |  |
| Support with breakfast  |  | Support with lunch |  | Support with evening meal  |  |
| Leave jug/flask |  | Leave jug/flask |  | Leave jug/flask |  |
| Transfers: bed/chair/toilet |  | Transfers: bed/chair/toilet |  | Transfers: bed/chair/toilet |  |
| Prompt / administer meds |  | Prompt / administer meds |  | Prompt / administer meds |  |
| Why is QDS POC required? |   |
| **Therapy only** Yes No  | **Requires visit on day of discharge** **Yes No**  |
| **Pathway Indicated 1 2 3**   |
| **Discharge hub recommendation****Time** | **Placement hub – confirmation of plan** **Time date of transfer** |

Email completed form to AdultsandHealthPlacementTeam@westsussex.gov.uk to refer and the BSUH discharge hub for audit bsuh.dischargecontrolgovernancecentre@nhs.net