|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NHS number  Patient sticker  Patient 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 No  Does 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](mailto:AdultsandHealthPlacementTeam@westsussex.gov.uk) to refer and the BSUH discharge hub for audit [bsuh.dischargecontrolgovernancecentre@nhs.net](mailto:bsuh.dischargecontrolgovernancecentre@nhs.net)