**ESD CENTRAL AREA REFERRAL FORM**

OneCall, Unit 5, The Quadrant, Marlborough Road, Lancing business park, Lancing, BN15 8UW

Tel: 01903254789 email: [sc-tr.onecallcoastalreferrals@nhs.net](mailto:sc-tr.onecallcoastalreferrals@nhs.net)

**Important:** *Please ensure the patient meets the referral criteria before completing this form.* **Note:** *Referrals without all the information will be returned to the referrer and not considered for assessment by the service.*

**DATE COMPLETED………………………………… DISCHARGE DATE…………………………………………**

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**Patient details**

|  |  |
| --- | --- |
| Title: | Date of Birth: |
| Name: | NHS Number: |
| Address: | Ethnicity |
| Next of Kin:  Telephone Number: |
| GP:  Telephone number: |
| Telephone Number: | Referrer Name:  Ward/Hospital:  Telephone Number: |
| Hospital Consultant: |

**Medical History**

|  |  |
| --- | --- |
| Current Diagnosis/Presentation (*Date of onset, Scan/investigation results/vision/tone/strength/sensation)* | |
| Past Medical History *(Include other medical conditions and Mental Health History)* | |
| Medication on discharge *(Or please provide medical discharge summary)* | |
| BP and Pulse readings: | |
| **DNAR Status** (*Please attach copy of form)* | |
| Infection Control Status | |
| NPDS- ***state score*** | Allergies |
| Waterlow | MUST |

**Social History**

|  |
| --- |
| *Environment, Key safe, Carelink* |

**Current Functional Status**

|  |
| --- |
| *Personal Care, Mobility, Toileting day/night, Medication management* |
| Communication |
| Continence |
| Swallow |
| Current Suicidal Ideations/Mood |
| Cognition |

**Rehab Goals**

|  |
| --- |
| ***SMART*** *Short and Long Term Goals, disciplines required* |

**CHECKLIST Yes No**

|  |  |  |
| --- | --- | --- |
| Does the patient require input from 2 or more disciplines? |  |  |
| Is the patient having a Package Of Care on discharge?- ***if ‘Yes’, please state details below*** |  |  |
| Has the referral been explained and the patient consented? |  |  |
| Is the required equipment and Pressure Care in place for discharge? |  |  |

**Additional Information –including any known risks to patients and/or staff (e.g. risk of falls, infection, violence etc.)**

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| --- |
|  |

Referrer Signature,

Name and Designation