|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name + Contact Details:** |  | **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.If aid required for mobility or equipment required for transfers’ please confirm if this will be in place prior to discharge Yes [ ]  No [ ] 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. |