|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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. | | | | | |