|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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:** Pt has a rapidly deteriorating condition which may be entering a terminal phase?  **Yes No**  Anticipatory medications have been provided **Yes No** | | | | | | | |
| **Pt with rehab or complex needs, requires community bed/NH option** please delete accordingly**. If not, write N/A** | | | | | | | |
| **Breathing:** current needs | | **Nutrition:** current needs | | **Continence:** current needs | | | |
| **Skin Integrity:** current needs | | **Mobility:** current needs | | **Communication:** current needs | | | |
| **Psychological & Emotional Needs** | | **Cognition:** current needs | | **Behaviour:** current needs | | | |
| **Altered States of Consciousness** | | **Drug Therapies & Medication: Symptom Control:** current needs: | | | | | |
| **Current Infection prevention and control status** | | | **Purpose T** | | | **MUST** | |
| Is patient already known to **community nursing** Yes No  Details of care:  **Is patient on WARFARIN?** Yes No | | | **Nursing** needs on discharge? Yes No  (clips, dressings, catheter, eye drops etc.)  Details:  **Anticoagulant**: time, date ends: | | | | |
| **Is patient on INSULIN?** Yes No Patient has own blood sugar monitor Yes No  Frequency of dose: …………………………………………  Community Nurses required for support with insulin Yes No N/A | | | | | | | |
| **Medication:** | | | | | | | |
| Can they self-administer **Yes** 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 | | **TTO ready and with patient: Yes No**  PLAN | | | | |
| **Follow up appointments**: | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patients name | | | DOB | | | | | | NHS number | |
| **Patient Goals** | | | | | | | | | | |
| What do you want to improve or manage once you are at home e.g. mobility, ADL’s? What matters to you? | | | | | | | | | | |
| **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: | | | | | | | | | | |
| **Stairs: Internal Yes No N/A**  **Access** to the patient’s home: steps etc. | | | | **Pendant alarm**  Yes No Other Telecare requested? | | | | **Key safe:** Yes No N /A  Contact details for key safe: | | |
| **MCA considered Yes No DoLS: in place whilst in hospital? Yes No**  Does patient have an allocated SW **Y N SW name:** | | | | | | | | | | |
| **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  Preference of carers? Female Male N /A | | | | | | | | | | |
| **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** | | | | | | | | | |
| **Reasons** | | | | | | | | | | |
| **Discharge hub recommendation**  **Time** | | | | | **Placement hub – confirmation of plan**    **Time date of transfer** | | | | | |