|  |
| --- |
| **SUBMIT YOUR REFERRAL BY** email to **esh-tr.hscc@nhs.net** or by phone **0300 678 0010** (8:00am – 10:00pm seven days a week including Bank Holidays). OOH calls from professionals are directed to the Integrated Night Service. * Patient details, Sticker can be used.
* GP Details
* NOK Details
* Carers details appropriate
* Your details
* Ward/Hospital patient is, reason for admission; please include EDD. (PMH comes later in form)
* Reason for your referral to HSCC, if for Rehab please include goals.
 |
| NB. Some systems will prepopulate some mandatory fields but **ALL MANDATORY FIELDS AND ADDITIONAL MANDATORY INFORMATION MUST BE SUBMITTED TO PREVENT DELAYS AND INAPPROPRIATE REFERRALS**  |
| 1. **Patient/Client Details**
 |
| **NHS Number** |       | **Social care ID**  |       |
| **Family name**  |       | **Given name**  |       | **Title** |       |
| **Preferred name**  |       | **Date of birth** |       | **Age** |       |
| **Gender** |       | **Transport requirements** |       |
| **Ethnicity** |       | **Marital status** |       |
| **Religion** |       | **Email address** |       |
| **Current address**  |       | **Home phone number** |       |
| **Post Code** |       | **Mobile phone number** |       |
| **Permanent address *(if different)*** |       | **Access information (*e.g. key code as appropriate)*** |       |
| **Post Code** |       | **Location at time of referral** |       |
| **Patient/Client’s GP Name**  |       | **Patient/Client’s Surgery phone number** |       |
| **Patient/Client’s Consultant** |       | **Patient/Client’s Surgery Post Code** |       |
| 1. **Next of Kin**
 | **MAIN CARER INFORMATION** |
| **Name** |       | **Name of main carer** |       |
| **Relationship** |       | **Relationship** |       |
| **Address**  |       | **Address**  |       |
| **Post Code** |       | **Post Code** |       |
| **Contact phone number:** |       | **Contact phone number:** |       |
| 1. **Referrer and Referral details**
 |
| **Referral time** |       | **Referral date** |       |
| **Referrer name** |       | **Referrer telephone no** |       |
| **Referrer Role e.g. GP, Paramedic, OT** |       | **Referrer organisation** |       |
| **Referrer address**  |       | **Referrer email** |       |
| **Post Code** |       | **Referrer CCG** | EHS [ ]  | H&R [ ]  | HWLH [ ]  |
| 1. **PATIENTS/CLIENTS IN ACUTE SETTINGS**
 |
| **Hospital and ward:**       | **Reason for admission:**       | **Anticipated discharge date:**       |
| 1. **REASON FOR REFERRAL - Please describe the patient/client’s medical diagnosis/condition, clinical and social care needs and, if requiring rehabilitation or reablement, the outcomes required from the service intervention**
 |
|       |
| 1. **please give the primary presenting need/S:**
* Tick any needs the patient has that will need support.
* Priority 2 for patients who are MRFD and MDT fit awaiting POC, IPR. If for therapy – if not discharge dependent tick appropriate response. If DN and requires next day visit please call HSCC for referral.
* Tick appropriate consent.
* Tick here for discharge from hospital.
* If a TTO has been written please send with referral. If not please fill in ALL boxes here.
* Risks to the patient that need to be known are written here.
* Please write COVID/ MRSA swab result and date here. If any other infections known please write here.
* DNAR? Please ensure red copy is sent with the patient on discharge.
 |
| **Falls [ ]**  | **Medication [ ]**  | **Mobility [ ]**  | **Nutrition [ ]**  | **Personal care [ ]** e.g. bathing, dressing | **Wound care [ ]**  | **Equipment [ ]**  |
| **Inpatient intermediate care [ ]**  | Other – please detail:       |
| 1. **Urgency of referral – response time for THE service/S REQUESTED to contact THE patient / CLIENT OR TO CONTACT THE REFERRER IF THE PATIENT / CLIENT IS IN AN ACUTE SETTING AND/OR AWAITING DISCHARGE**

***NB. Referrers should telephone HSCC for any Priority 1 referrals. For referrals where multiple services have been requested, please name the service/s against the priority you assign to them*** |
| Priority 1: Contactwithin 2 hrs [ ] **Call: 0300 6780010****Service:**       | Priority 2: Contact within 4-8 hours [ ] **Service:**       | Priority 3: Contactwithin 24-48 hours [ ] **Service:**       | Priority 4: Contact within 48-72 hours [ ] **Service:**       | Priority 5: Contact within 5 working days [ ] **Service:**       |
| 1. **CONSENT *NB. Consent must be provided or the referral cannot be accepted***
 |
| **Has the patient/client or their representative consented to the referral and for their information to be shared with appropriate services?**  | **Yes [ ]**  | **No [ ]**  |
| **OR If not please confirm that the referrer has made the referral believing it to be in the best interests of the person concerned** | **Yes [ ]**  | **No [ ]**  |
| **OR If the patient/client lacks the capacity to decide whether to consent to this referral and the sharing of the information contained within this referral form, has the referrer made the referral believing it to be in the best interests of the person concerned?**  | **Yes [ ]**  | **No [ ]**  |
| **Is this referral required to avoid an acute hospital admission?** | **Yes** | **[ ]**  | **No** | ***[ ]***  |
| **Is this referral required to assist a hospital discharge?** | **Yes** | **[ ]**  | **No** | ***[ ]***  |
| **Do you know what service/s (from the list below) may be required?**  | **Yes** | **[ ]**  | **No** | ***[ ]***  |
| 1. **Medical Details (Please include below or attach) NB. referrals cannot be processed without a medical summary**
 |
| **Medical summary including medication**  |       |
| **Significant medical history**  |       |
| **Current repeats (medications, treatment, symptoms)** |       |
| **Allergies/Drug Allergies** |        |
| 1. **Alerts/Risks**
 | **if Yes please provide details** |
| **Known risks to self** |        | **Special dietary needs** |        |
| **Known risks to others** |        | **Communication support/Sensory needs** |        |
| **Recent/risk of infection** |        | **Interpreter/Advocate required** |        |
| **Risk of falls** |        | **Mental capacity needs** |        |
| **Is the patient/client a Carer?** |       | **Advance decision made/DNACPR** |       |
| 1. **If you know the service/s required, please select from THE list below:**
 | **PLEASE SUPPLY THE FOLLOWING Additional mandatory information WHICH IS required BY THE RECEIVING SERVICE TO ACCEPT THE REFERRAL** |
| **Adult Social Care Assessment / Carers Assessment and/or social care services including occupational therapy** * For all patients IPR (not stroke or NWB) tick here, fill out all relevant information. Ensure you attach goals, drug chart, recent bloods and observations.
* Stoke IPR tick here, fill out all relevant information. Ensure you attach goals, drug chart, recent bloods and observations.
 | [ ]  | None  |
| **Carers Breaks**  | [ ]  | 1. **Reason for support?**
2. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]
3. **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]
4. **Rapid Response Referral i.e. within 1 hour? Yes** [ ]  **No** [ ]
 |
| **Carers Breaks Dementia Guide Service** (HWLH CCG area only) | [ ]  | 1. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]  **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]  **Low** [ ]
2. **Date given:**
3. **Are there any other circumstances the Dementia Guide Service should be aware of prior to contact?**
4. **If first contact is requested through a third party, provide their name, relationship to client, phone numbers:**
 |
| **Community Bed** *NB. to ensure their safety and suitability for therapeutic input patients/clients must be medically stable and have low to moderate mental health needs including dementia* | [ ]  | 1. **MUST:**
2. **NEWS score:**
3. **Purpose T/Waterlow scores:**
4. **Continence Issues:**
5. **Infection control status:**
6. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]  **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]  **Low** [ ] **Rehabilitation Goals:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
7. **Package of care in place:** **Yes** [ ]  **No** [ ]
8. **Community prescription chart (please attach)**
 |
| **Community Bed - Irvine Unit (Stroke)***NB. to ensure their safety and suitability for therapeutic input patients/clients must be medically stable and have low to moderate mental health needs including dementia* | [ ]  | 1. **Date of stroke:**
2. **MUST:**
3. **Purpose T/Waterlow scores:**
4. **Continence Issues:**
5. **Infection control status:**
6. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]  **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]  **Low** [ ] **Rehabilitation Goals:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
 |
| **Community Bed – Milton Grange (Mental Health Intermediate Care)***NB. to ensure their safety patients/clients must be medically stable* | [ ]  | 1. **Completed Support Plan (please send with referral)**
* Only can be accessed via a social worker, only refer here if requested.
* If TWOC required or new incontinence. If patient is house bound or has a catheter please complete nursing referral too.
* DN’s – please ensure you send wound care charts and prescription charts as appropriate.
1. **MUST:**
2. **Purpose T/Waterlow scores:**
3. **Continence Issues:**
4. **Infection control status:**
5. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]  **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]  **Low** [ ] **Rehabilitation Goals:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
 |
|  **Community Bladder and Bowel Service** (EHS and H&R CCG areas only)*NB. All patients who are housebound should be referred to the Community Nursing Service for an initial Bladder/Bowel assessment* | [ ]  | 1. **Bladder problem:**     If bladder problem please ensure urine dipstick has been carried out and patient has been treated accordingly before referral is made
2. **Bowel problem:**     If bowel problem per rectal (PR) examination to be done as appropriate (if not please state reason):

Red flags must be investigated prior to referral as appropriate |
| **Community Dietetics** (HWLH CCG area only) | [ ]  | 1. **Current weight:**       **Previous weight:**
2. **Current height:**
3. **BMI:**
4. **If malnutrition/weight loss identified, please provide:**

**MUST Score     ; Prescribed Oral Nutritional Supplements? Yes** [ ]  **No** [ ] 1. **Recent blood tests:**
2. **Is the GP aware of this referral? Yes** [ ]  **No** [ ]
3. **Is the patient able to attend clinic? Yes** [ ]  **No** [ ]
4. **Outcome expected from the service intervention:**
 |
| **Community Nursing/District Nursing/ACNP** *NB. referrals for phlebotomy services are only available via HSCC if linked to a referral for another nursing need* | [ ]  | 1. **Start date of support:**
2. **Community prescription chart if required (please attach)**
3. **IV referral checklist if required (please attach)**
4. **Syringe driver drug chart if required (please attach)**
5. **Advanced decision: Yes** [ ]  **No** [ ]  **Don’t know** [ ]
6. **DNACPR form:** **Yes** [ ]  **No** [ ]  **Don’t know** [ ]
 |
| **Community Stroke Rehabilitation Team**  | [ ]  | 1. **Date of Stroke:**
2. **Confirmed diagnosis**:
3. **CT/MRI Results:**
4. **Early Supported Discharge: Yes** [ ]  **No** [ ]
5. **Modified Rankin Scale on discharge from an in-patient setting for stroke clients:**      **Rehabilitation Goals:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
 |
| **Community Stroke Early Supported Discharge** (EHS and H&R CCG areas only) | [ ]  |
| **Crisis Response Service**: up to 72 hours support for patients/clients who are medically optimised and do not require an acute hospital bed (EHS and H&R CCG areas only) | [ ]  | 1. **Start date of support:**
* If requesting for therapy at home tick here.
* For package of care at home tick here.
* Ensure you send goals with referral.
1. **NEWS score:**
2. **Package of care in place: Yes** [ ]  **No** [ ]
3. **Sitter required: Yes** [ ]  **No** [ ]
4. **Community prescription chart (please attach)**
5. **IV referral checklist with appropriate drugs supplied to the patient/client (please attach)**
6. **Syringe driver drug chart if relevant (please attach)**
 |
| **Frailty Practitioner Service** (EHS and H&R CCG areas only) | [ ]  | **Please complete the Frailty Service referral form and send to HSCC** |
| **Integrated Night Service (INS)** | [ ]  | **Telephone HSCC** who will complete the INS referral form with you. Out of Hours: Referrers calls will divert to the INS who will take the referral over the phone |
| Joint Community Rehabilitation (JCR) Service - time limited intervention to promote faster recovery from illness and/or injury |  |  |
| **JCR Rehabilitation and Falls Prevention**: to optimise function (mobility, targeted exercise and activities of daily living) through assessment and treatment from Occupational Therapists, Physiotherapists, Rehabilitation Nurses and Rehabilitation Support Workers | [ ]  | 1. **Is the patient/client medically stable (defined as no longer requiring consultant led acute/inpatient medical intervention):** **Yes** [ ]  **No** [ ]
2. **Rehabilitation/reablement goals/therapy intervention:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
3. **The patient/client would benefit from assessment and therapeutic or rehabilitation/reablement intervention: Yes [ ]  No [ ]**
4. **The patient/client is not impeded by medical precautions or** **the current stage of medical treatment:** **Yes** [ ]  **No** [ ]
5. **If referral is for reablement homecare, please attach a completed Support Plan if available, if not give an indication of the purpose and frequency of visits needed here**:
6. **Social Care ID if known:**
* Write how many visits the patients requires here (e.g BD/ TDS). If OD when would this need to be?
* For all patients requiring a Non Weight Baring bed tick here, fill out all relevant information. Ensure you attach goals, drug chart, recent bloods and observations.
* Any information that is relevant that is not elsewhere on this form.
* Please tick for consent to Summary Care record (GP record).
 |
| **JCR Reablement**: for the personal care element supporting the client to do things for themselves / adapting to regain independence /reach optimal level, delivered by Support Workers | [ ]  |
| **Multiple Sclerosis Community Nursing Service** (HWLH CCG area only) | [ ]  | **Please ensure Section 5: Reason for Referral has been completed including diagnosis and any relevant information** |
| **Non-Weight Bearing Beds (for rehabilitation only)** | [ ]  | 1. **MUST:**
2. **Purpose T/Waterlow scores:**
3. **Continence Issues:**
4. **Infection control status:**
5. **Has the patient had a dementia screening:** **Yes** [ ]  **No** [ ]  **Level of cognitive impairment:** **High** [ ]  **Medium** [ ]  **Low**
6. **Rehabilitation Goals:** If assessed, please attach. If not assessed please give the outcome required from the service intervention in the ‘reason for referral’ section or here:
 |
| **Parkinson’s Community Nursing Service** (HWLH CCG area only) | [ ]  | **Please ensure Section 5: Reason for Referral has been completed including diagnosis and any relevant information** |
| **Respiratory Service including Pulmonary Rehabilitation**  | [ ]  | **Please complete the relevant referral form/s (for the CCG area the patient’s GP is located) and send with your completed HSCC referral form** |
| **Respiratory Service Home Oxygen Service**  | [ ]  |
| **SALT - Speech and Language Therapy Team** (EHS and H&R CCG areas) | [ ]  | **Referral for: Communication** [ ]  **Swallowing** [ ] **If the patient is vulnerable, list any safeguarding issues:**       **Are they home bound or could attend clinic?**       |
| **SALT - Speech and Language Therapy Team** (HWLH CCG area) | [ ]  | **Referral for: Communication** [ ]  **Swallowing** [ ] **Please complete and return the HWLH Adult SALT additional information form with a completed HSCC referral form** |
| 1. **Further information to support the referral**
 |
| Have you referred to any other service/s? *If Yes, please describe which below.* |
|       |
| Has the patient/client given permission to access their summary care record*? If not please provide reason below.*  | **Yes** | **[ ]**  | **No** | **[ ]**  |
|       |
| **Accessible information standards (Legal Requirement):**Communication support required [ ]  Type of support e.g. sign language, lip reader:       Specific contact required [ ]  Type of contact e.g. telephone, text, letter, email:      Specific information required [ ]  Type of contact e.g. verbal, easy read, email, moon alphabet:      Communication Professional required [ ]  Type of professional support e.g. interpreter, BSL, Makaton, advocate:       |
| **For HSCC Office Use only** |
| **Priority assigned by HSCC after triage** | **P1 [ ]**  | **P2 [ ]**  | **P3 [ ]**  | **If different from that assigned by referrer, has the referrer been informed** | **Yes [ ]**  | **No [ ]**  | **Date and time**       |
| **P4 [ ]**  | **P5 [ ]**  |  |
| **Exceptions reported by HSCC:**       |
| **Exceptions reported by the receiving service - select reason below:** |
| Service changed the priority assigned | [ ]  | Service lacks capacity | [ ]  | Service not open or available | [ ]  | Service refused patient/client (inappropriate referral) | [ ]  | Other: Describe       |
| **Service referred into** |  | **If different from that requested by referrer, has the referrer been informed** | **Yes [ ]**  | **No [ ]**  | **Date and time**       |