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| **Patient Name:****NHS No:**  **ADDRESSOGRAPH****D.O.B:** **Address****Tel no:** **Male / Female (circle)**  | **Date of Admission:** **ReSPECT in place?** [ ] **ADRT in place?** ☐**DNACPR in place? Yes** [ ]  **No** [ ] **Date completed:** **MRFD** [ ]  **NMRFD** [ ]  **EDD:** **TTO’s:** [ ]  **Discharge Summary:** [ ]  | **Referring Hospital** **& Date:****Referring Ward:** **Ward Contact Number:** |
| **GP Practice:** **County:** **Postcode:**  |
| **Consultant / Specialty :**  |
| **Ethnicity:** **Religion:**  | **Consent obtained from patient for:** **Referral Yes** [ ]  **No** [ ] **Share info Yes** [ ]  **No**  [ ] Has a conversation with the relative been had regarding discharge **Yes** [ ]  **No** [ ] Reason if not**:** | **Next of Kin Name:** **Relationship:** **Address:** **Contact number:**  |
| **Preferred Language: English****Interpreter required: Yes** [ ] No [ ]  |
| **Summary of admission (Inc. diagnosis, treatment & PMH.** | **Operation & Date: N/A** |
| **Secondary care follow up appointment date:**  |
| **Current Medication & Support (tick) - send copy of drug chart** **List any Allergies: Pain Score:**  |
| Can they self-administer? **Yes** [ ]  **No** [ ]  If no, please state who was providing support with this:Is the medication supplied in BOXES/BLISTER PACKS at home \*delete as appropriate  | Was patient on insulin prior to hospital admission? **Yes** [ ]  **No** [ ]  Frequency of Insulin dose………………………….Does the patient own a blood sugar monitor? **Yes** [ ]  **No** [ ]  | Is the patient on Warfarin / DOACs? **Yes** [ ]  **No** [ ]  |
| Is patient on Eye drops?**Yes** [ ]  **No** [ ]  |
| PICC Line in-Situ: **Yes** ☐ IVs at Home: **Yes** ☐  |
| Current Observations: Date taken:  HR BP Resps SatsTemp Current NEWS2: |
| Describe any Breathing problems: | Home oxygen? Yes [ ]  No [ ]  O2 Litres: Frequency:  |
| **Covid-19**  Test not required / [ ] Date swab taken: ….. /….. /.. …. & awaiting result [ ]  Exposed to C-19 & needs Isolation [ ]  Result Negative, no isolation [ ]  Result Positive & needs isolation [ ]   | **Flu Vac** - date if known: ESBL (E.coli) Yes [ ]  No [ ]  Date: MRSA +ve Yes [ ]  No [ ]  Date: (site)C/Difficile +ve Yes [ ]  No [ ]  Date: | Any evidence of infective diarrhoea? If yes, describe:Other Infections:  |
| **Wounds: If Yes** [ ]  **please send wound care plan with referral Nil** [ ] **Purpose T Score: or BRADEN Score:** **Are Pressure Areas Intact Yes**  [ ]  **No**  [ ]  **Grade (circle) 1 2 3 4** |
| **End of Life Needs:**  | Patient has a rapidly deteriorating condition entering a terminal phase: **Yes**  [ ]  **No** [ ]  Anticipatory medications have been prescribed & provided: **Yes**  [ ]  **No**  [ ]  |
| **Discharge Pathway Indicated (tick)****1** [ ]  **2** [ ]  **3** [ ]  | If the patient known to community nursing, provide details:  |

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| **Nutrition – Eating & drinking – current needs** |
| Independent | AX1 | Full support | PEG/NG |
| MUST score: Weight: Girth: Height: BMI:  |
| Dietician Referral: **Yes**  [ ]  **No**  [ ]  Date:  | SALT Referral : **Yes**  [ ]  **No**  [ ]  Date:  |
| TPN prescribed: **Yes**  [ ]  **No**  [ ]   | Dentures in situ: **Yes**  [ ]  **No**  [ ]   |
| **Continence – current support required e.g. pads/assistance**  |
| Commode | Urinal/bottle | Toilet | Wears pads  | Urethral/Suprapubic  |
| Bladder: Continent or incontinent? | Catheter/ Conveen Catheter passport required |
| Bowels: Date last opened : Type : Continent or incontinent?  |
| **Night time needs - current** |
| Independent | Urinal/bottle | Commode | Bedpan | Turning |
| Night time assistance required – details: |
| **Cognition/current needs regarding Emotional & Mental Health / Behaviours (Select or tick as appropriate)** |
| AlertOrientatedConfusion/ disorientatedDelirium? | Types of behaviour displayed (list)Bay Buddy in place? [ ]  1:1 in place? [ ] List Strategies to manage, Inc. night needs? MH or Dementia team involved? [ ]  Section 117? [ ]  | Any episodes of wandering during the day or night? Mild memory issues  |
| **Diagnosis** of mental health issues: Substance misuse/ self-neglect / significant anxiety +/- depression**Diagnosed** cognitive problems: Dementia / Alzheimer’s / Bi polar | Can they be cared for in a side room? Yes [ ]  No [ ] Can they use a call bell?Yes [ ]  No [ ] Has a care log been completed? Yes [ ]  No [ ]  | Describe any barriers to communication: | AMTS: 6CIT:  4AT: MoCA:  |
| Is the patient open to Dementia/Mental Health/LD services?Contact details: |
| **Mental Capacity** Does the patient have capacity? **Yes** [ ]  **No** [ ] Best Interests decision documented **Yes** [ ]  **No**  [ ]  DoLS: In place whilst in hospital: **Yes** [ ]  **No**  [ ]  | **Lasting Power of Attorney/DEPUTY** Health & Welfare: **Yes** [ ]  **No** [ ]  Finance: **Yes** [ ]  **No** [ ]  |
| Safeguarding concern details:  |
| **Brief social history e.g. How did patient manage pre-admission? Independent? Mobility? Lives alone?** |
| Accommodation Type: (tick) House [ ]  Bungalow [ ]  Flat [ ]  Supported living [ ]  Residential Home [ ]  Nursing Home [ ]  Mobile home [ ]  Bed & Breakfast [ ]  Homeless [ ]  |
| **Previous POC** **Yes** [ ]  OD BD TDS QDS Double handed Reason: Care agency Contact no: No POC [ ]  Does patient have a live-in carer? **Yes** [ ]  **No** [ ] Does patient have informal carers e.g. family, neighbour, friend? **Yes** [ ]  **No** [ ] Are they able to continue this level of care? **Yes** [ ]  **No** [ ]  Details:Self-Funding: **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| Does patient have an allocated Social Worker? **Yes** [ ]  **No** [ ]  S/W Name:  | Key safe:  **Yes** [ ]   **No** [ ]   **NA** [ ]  Contact details for key safe: | Stairs: **Yes**  [ ]  **No** [ ]  Internal/external Unable to use stairs **Yes**  [ ]  **No** [ ]  Access to the patient’s home: steps etc. | Pendant alarm: **Yes** [ ]  **No**[ ]  **Other:** Telecare requested? |
| **Washing & dressing - current** |
| Independent |  With Supervision / AX1  | AX2 | Non-compliant (details) | Other |
| **Mobility & transfer needs – current**  |
| Independent | With Supervision /Elbow crutches AX1/AX2 | Walking stick AX1/AX2 | Tripod/quadstick AX1/AX2 | Walking frame AX1/AX2 |
| Gutter/pulpit frame AX1/AX2 | Rotastand/standaidAX1/AX2 | HoistAX2 | 4 wheeled walker AX1/AX2 | FWB/PWB/NWBAX1/AX2 |

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| **Patient Goals & Priorities:** |
| **Safety Checklist for Discharge:** | **Risk of Falls? Yes** [ ]  **No** [ ]  |
| Patient is physically and cognitively safe to be left alone BETWEEN visits. Day & night? **Yes** [ ]  **No** [ ]  |
| Describe how the patient will manage (plus any risks). Include how the patient will mobilise and transfer and any cognitive or communication issues: |
| **Current Equipment needed on discharge and date of delivery** |
| Hospital Bed | Pressure Mattress Type | Standard / Bariatric | Commode/Mowbray | Other: |
| **Size of Package of care needed on discharge (select):** None [ ]  OD [ ]  BD [ ]  TDS [ ]  QDS [ ]  Double Handed: **Yes**  [ ] Preference of carers? Female [ ]  Male [ ]  NA [ ]  Family to bridge care? **Yes** [ ]  **No** [ ]  |
| **Frequency of support required:**  | **Is this POC: New, Increase, Restart, Long term, Short term** |
| **AM** | Tick | **Midday** | Tick | **Teatime** | Tick | **Evening**  | Tick |
| Enable wash & dress |  |  |  | Enable to get ready for bed |  | Enable to get ready for bed |  |
| Empty commode |  | Empty commode |  | Empty commode |  | Empty commode |  |
| Supervise downstairs |  |  |  | Supervise up stairs |  | Supervise up stairs |  |
| Support with breakfast  |  | Support with lunch |  | Support with evening meal  |  |  |  |
| Leave jug/flask |  | Leave jug/flask |  | Leave jug/flask |  | Leave jug/flask |  |
| Transfers: bed/chair/toilet |  | Transfers: bed/chair/toilet |  | Transfers: bed/chair/toilet |  | Transfers: bed/chair/toilet |  |
| Prompt administer meds |  | Prompt /administer meds |  | Prompt / administer meds |  | Prompt / administer meds |  |
| **Therapy only** **Yes** [ ]  **No** [ ]   | **Requires visit on day of discharge** **Yes** [ ]  **No** [ ]  |  **Has a home visit been completed** **Yes**  [ ]  **No**  [ ]   |
| **Reasons:**   |
| **Relevant / Additional Information:** |
| **Referrers Signature:****Designation** | **Print Name:****Contact Number:** | **Date:** |
| **Contributors Signatures:****Designation:** | **Print Name(s):** | **Date:** |
| **Discharge Hub Recommendation****Time:** | **Placement Hub – confirmation of plan** **Time:**  | **Date of Transfer:** |