Admission Assessment,Transfer & Referral Document

Brighton and Sussex University Hospitals NHS Trust

Key patient details

Family name		Telephone (main)	
First name(s)		Telephone (other)	
Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr	Preferred name	
Permanent address: Postcode: *Attach PAS label if available*		Current address (if different): Postcode:	
		Marital status	
Date of birth		Religion	
Hospital No.		Ethnicity	
NHS No.		Occupation	
GP name and address		Preferred language	
		Communication issues	☐ No ☐ Yes *(detail):* Interpreter required ☐ Yes ☐ No
GP telephone			

Key admission information

Admission date		Estimated date of discharge	
Hospital		Ward	
Reason for admission:		Past medical history:	

Allergies ☐ No ☐ Yes *(detail):*

Are there any safeguarding issues ☐ No ☐ Yes (detail):

Are there any known risks to self or others ☐ No ☐ Yes (detail):

Next of kin details

Next of kin (NOK)		Relationship	
Permanent address: Postcode:		Telephone (main) Telephone (other)	
Is NOK in good health		☐ Yes ☐ No *(detail):*	
Is NOK aware of admission		☐ Yes ☐ No	
Do you give consent for your NOK to be informed of your condition		☐ Yes ☐ No *(detail):*	
Is NOK agreeable to be contacted at any time for changes in patients condition (including a fall)		☐ Anytime ☐ Day only ☐ Other *(detail):*	
2nd contact (if applicable)		Telephone (main) Telephone (other)	
Relationship			

Referrals

Social work *(e.g. package of care, nursing home etc):*

Remember to complete nursing assessment

Referrer		Date		Ward		Ex. no.	

Occupational therapy *(e.g. activities of daily living assessment or equipment):*

Referrer		Date		Ward		Ex. no.	

Physiotherapy *(e.g. chest physio, mobility, stair assessment, rehab goals etc):*

Current mobility: Aids:
Transfers (circle) : *Independent / assistance 1 / 2*
Distance (circle) : *0m / <5m / 10m / >10m*

Mobility prior to admission: Aids:
Transfers (circle) : *Independent / assistance 1 / 2*
Distance (circle) : *0m / <5m / 10m / >10m*

Referrer		Date		Ward		Ex. no.	

Rehabilitation *(e.g. in-patient, out-patient etc):*

Is the patient aware that the Rehab team will assess where they will be placed according to their need? *Yes / No*
Remember to send OT/physiotherapists rehab goals and complete infection control section over page

Referrer		Date		Ward		Ex. no.	

District nurse *(e.g. wound care etc):*

Date first visit required: .....(date) *Remember to include wound care plan etc*

Referrer		Date		Ward		Ex. no.	

Urinary catheters (complete / circle as required):

Date inserted ..... Reason for insertion ..... Residual volume .....

Any complications with catheterisation: *No / Yes* (detail): .....

Catheter site: *Urethral / Suprapubic* Catheter in situ: *Long term / Standard term* Catheter size: .....

Next change due .....(date) By: *District Nurse / Nursing Home / Hospital OPA*

Antibiotic cover required: No / Yes (detail) .....

Management plan:
Trial without catheter: *No / Yes* : .....(date)
Awaiting surgery: *No / Yes* : .....(date)
Long term catheter: *No / Yes*

Has the patient had a catheter acquired infection while in hospital: No / Yes (detail below):

Date: ..... Organism: ..... Treatment: .....

Supplies given to patient/carer: Yes / No
Patient/carer instructed in catheter care: Yes / No
Registered with home delivery service: Yes / No
Catheter Passport completed and given to patient: Yes / No

Referrer		Date		Ward		Ex. no.	

Other *(specify):*

Referrer		Date		Ward		Ex. no.	

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