**Waltham Forest Adult Community Health Services referral form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| ***This top section must be completed in full or the referral will be rejected*** | | | | | | | | | | | | | | | | | | | | |
| **Surname:** |  | | | **First Name(s):** | | | | | | |  | | | | | **Male** | | | **Female** | |
| **Date of Birth:** |  | | | **NHS No.** | | | | | | |  | | | **Hospital No**: | | | |  | | |
| **Ethnicity**  (please tick relevant box) | *White:* | |  | | | |  | | | | | | Any other White background | | | | | | | |
|  | *Mixed:* | | White & Black Caribbean | | | | White & Black African | | | | | | White & Asian | | Any other mixed background | | | | | |
|  | *Asian or Asian British:* | |  | | | |  | | | | | |  | | Any other Asian background | | | | | |
|  | *Black or Black British:* | |  | | | |  | | | | | | Any other Black background | | | | | | | |
|  | *Other Ethnic Groups:* | |  | | | | Any other ethnic group | | | | | |  | | | | | | | |
| **Current Home Address** |  | | | | | **GP Name** | | | | | |  | | | | | | | | |
|  |  | | | | | **GP Address** | | | | | |  | | | | | | | | |
| Post code: |  | | | | | Post code: | | | | | |  | | | | | | | | |
| Phone: |  | | | | | Phone: | | | | | |  | | | | | | | | |
| Mobile: |  | | | | | Mobile: | | | | | |  | | | | | | | | |
| *Is this address home permanent or temporary?* | | | | | | | | Permanent | | | | | | | Temporary | | | | | |
| **Primary Language Spoken:** | | **Main spoken language English** | | | | | | | | **Interpreter Required:** | | | | | Yes | | No | | | |
| **Is the Patient Housebound?** | | Yes | | | No | | | | **Does patient require Hospital Transport** | | | | | | Yes | | No | | | NA |
| **Has this referral been discussed with and agreed by the patient?** | | | | | | | | | | | | | | | Yes | | No | | | |

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| **Indicate reason for referral and which function(s) you are referring your patient to** | | | | |
| **Reason for referral (s)**  ***Referral will be delayed if this section is incomplete or if reason for referral does not relate to all functions selected below.*** Please include therapy goals, past treatments and history of presenting problem where relevant. | | | | |
|  | | | | |
| **Unplanned Care** | | Rapid Response Service (admission avoidance & urgent care | | |
| **Planned Care**  ***(please tick below function (s) and the input required for each function)*** | | | | |
| **District Nursing /function**  Urgency of response required:  Response expected within 24 to 48 hrs)  Response expected within 3 to 5 days | | **Therapy Rehabilitation Service**  ***Please tick the specific service below***   * WF rehabilitation unit (Ainslie)  * Falls Prevention  * Community Rehabilitation Team | | **Community Matrons/Case Management & Therapy** |
|  | |  | | **Palliative/End Of Life Care (EPIC)** |
|  | |  | | **Tissue Viability Service**  **Note for wound dressing refer to DN** |
| Waterlow Score: |  | Risk score if known: |  | **Podiatry** |
|  |  |  |  | **Continence Service** |
|  |  |  |  | **Nutrition and Dietetics** |
| **Diabetes / Education**\*:  Diagnosed in last 12 months  Must complete BMI, Chol, HbA1c, BP on page 2  *\* Include copy of blood results (HbA1c, U&E and LFT), medication list and medical history\**  **Please see end of form** | | **Community Respiratory Team**  Pulmonary Rehab (PR)  COPD Home support  Spirometry  Baseline FEV1  Asthma Care | | ***Specialist services*** |
|  | |  | | **Parkinson’s** |
|  | |  | | **Multiple Sclerosis** |
|  | |  | | **Haemoglobinopathy**  **Phlebotomy** |
|  | |  | |  |

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| **Name of Referrer:** | **Date of Referral:** | **Phone/Mobile:** | | |
|  |  |  | | |
| **Profession/Job Title:** | **Organisation / Hospital / Ward:** | Additional reports attached: | Yes | No |

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| **Next of Kin / Person to Contact:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship: | | | | | | | | | |  | | | | | | | | | | Phone Number/s: | | | | | | | |  | | | | | | | | |
| **Relevant Medical History** (diagnosis, recent illness, recent hospital admissions, investigations/results, Long Term Condition). | | | | | | | | | | | | | | | | | | | | | | | | | If not relevant to this referral, please tick | | | | | | | | | | | |
| Please attach summary of medical history: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | Weight: | | | BMI: | | | | BP: | | | | | | | | Chol: | | | | | | HbA1c: | | | | | | | FEV1/FVC: | | | | eGFR: | | | |
|  |  | | |  | | | |  | | | | | | | |  | | | | | | **5 /mol** | | | | | | |  | | | |  | | | |
| **Current Medication** (include mode of administration /difficulties in taking) Please attach Medication list | | | | | | | | | | | | | | | | | | | | | | | | **Authorising signature**  **(Please type)**  Name of GP/Medical practitioner who is authorising district nurses to administer medication  ***Note separate authorisation to administer form must be completed*** | | | | | | | | | | | | |
| **Please see end of form** | | | | | | | | | | | | | | | **No drug allergies**  **No known drug allergies**  **Allergies (enter below)** | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | X | | | | | | | | | | | | |
| (Ensure full details of medications being authorised for DN’s to administer are listed as attached ‘authorisation to administer form’ | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **If applicable, recent Hospital admission** | | | | | | | | | | **Date of Admission** | | | | | | | |  | | | | | | **Date of Discharge** | | | | | | | |  | | | | |
| Details of Equipment / Dressings | | | | | | | | | | |  | | | | | | | | | | | | | Details of Care Package | | | | | | | |  | | | | |
| Other relevant discharge information | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health, Social Issues and Risks**  (e.g. functional/mobility problems, communication, confusion, memory loss, nutrition/diet, hearing, vision, mental health, bed bound) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Smoker? | | | Yes | | | No | | | | | | Consumes Alcohol? | | | | | | | | | Yes | | No | | | | | | | Risk of falls? | | | | Yes | No |
| Does patient live alone? | | | | | | | Yes | | | | | | No | | | | | | Risks to patient or person visiting? | | | | | | | | | | | | | | | Yes | No |
| Is person being cared for? | | | | | | | Yes | | | | | | No | | | | | | *Details if yes* | | |  | | | | | | | | | | | | | |
| Key Safe | | Yes | | | No | | | | Key Holder Name | | | | | | | |  | | | | | | | | | | Key Holder Phone | | | |  | | | | |
| Number | |  | | | | | | |  | | | | | | | |  | | | | | | | | | |  | | | |  | | | | |
| Is patient known to Social Services? | | | | | | Yes | | | | | | No | | Contact details of social worker/care manager | | | | | | | | | | | |  | | | | | | | | | |
| Services / Support currently being received (details and contact names/numbers)  (e.g. personal care, community nurse, community matron, day centre, mental health, Community Rehab/Falls Team, consultant) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**Please send referrals at least 24-48hrs** before the patient requires a visit, particularly if medication administration is required.

Send referral to Waltham Forest CHS Adults Service (08.00 until 17.00 Monday to Friday)

Please email all completed referral forms whenever possible

**Email:** wfadultchsreferrals@nelft.nhs.uk **Phone**: 0300 300 1710

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| **SPA triage use only** | | | |
| Urgent (RRT) same day response | Response 24 to 48 hours of referral | | Response 3 to 5 days of referral |
| Comments | | | |
| Name: | Signature: | Date: | |