**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. |
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| **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:  |