**Referral form for:**

Community Hospitals

Intermediate Care, Community Nurses, Falls

Community Therapy services

Social Care

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | **Next of Kin** | | | | |
| Name |  | | | | | | Name | | | | |
| DoB |  | | | | | | Relationship | | | | |
| Address |  | | | | | | Phone | | | | |
| Post code |  | | | | | |  | | | | |
| Phone |  | | | | | |  | | | | |
| Registered GP | | |  | | | | | | | | |
| **Referrer’s Details** | | | | | | | | | | | |
| Name | |  | | | | | | Ward/Base |  | | |
| Practice | |  | | | | | | Phone/Bleep |  | | |
| Date of referral | |  | | | | | | Time of referral |  | | |
| **Reason for referral** (please include any cognitive issues) | | | | | | | | | | | |
| **(last consultation)** | | | | | | | | | | | |
| **Anticipated Outcome of referral** | | | | | | | | | | | |
| Social Care | | | |  | | Community Nursing | | | |  | |
| Community hospital placement | | | |  | | Falls assessment | | | |  | |
| Intermediate care placement | | | |  | | Community physiotherapy | | | |  | |
| Intermediate care at home | | | |  | | Community occupational therapy | | | |  | |
| **Social Situation** (any lone working/safeguarding concerns) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Falls** | | | | | | | | | | | |
| Recurrent falls | | | | |  | Single injurious fall | | | | |  |
| Single fall with balance or gait problems | | | | |  | History of fragility fracture if over 50 years of age | | | | |  |
| Number of falls in the last 12 months | | | | |  | Osteoporosis treatment | | | | |  |
| **Relevant Medical History** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Current Medication** (include any known allergies) | | | | | | | | | | | |
| Has medication been considered and excluded as a likely cause of falls or presenting complaint?  If not what outstanding concerns remain | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Investigations carried out** | | | | | | |
| Blood Pressure (BP) |  | | | | | |
| Lying/standing BP | If postural drop present is patient symptomatic | | | | | |
| Pulse |  | | | | | |
| Respiratory Rate |  | | | | | |
| Oxygen Saturation |  | | | | | |
| Early Warning Score |  | | | | | |
| Urinalysis |  | | | | | |
| Microbiology |  | | | | | |
| Blood Results |  | | | | | |
| Radiology |  | | | | | |
| Electrocardiogram (ECG) |  | | | | | |
| Examination Findings |  | | | | | |
| **Clinical Management Plan** | | | | | | |
| Further medical investigations required | |  | | | | |
| Clinical monitoring required | |  | | | | |
| **Supporting Information to be attached** (please tick if attached) | | | | | | |
| GP summary profile | | |  | | Treatment Escalation Plan (if completed) |  |
| Care planning summary (if recently discharged from hospital) | | |  | | Comprehensive Geriatric Assessment  (if completed) |  |
| **For community hospital admissions please also attach** | | | | | | |
| Completed TEP form (essential) | | | |  | Medicines reconciliation |  |
| VTE assessment | | | |  |  |  |
| **Consent** | | | | | | |
| I confirm that the above patient or their advocate has been involved in the discussion regarding this referral and has given their consent: | | | | | | |
| Name:…………………………………………………….. Designation:………………………………… ……..  Signature: ……………………………….. …………….. Date:……………… | | | | | | |