**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:……………… |