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| **Adult Community Services** Referral formGP Surgeries - Please email referrals to:**lcft.MAP@nhs.net** Email referrals to: MAP@lscft.nhs.uk Tel: 01772 777 999 Fax: 01772 520 520  |

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|  **All sections must be fully completed, if not known please indicate.****REFERRAL DATE:** |

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| ***SECTION 1 PATIENT DETAILS*** |
| *NHS No:*  | *Date of Birth:*  | *Gender*  |
| *Title:*  | *First Name:*  | *Surname:*  | *Preferred Name:*  |
| *Address:*  | *Postcode:*  | *Tel No:* *Mobile No:*  |
| *Discharge Address (if different) :* | *Postcode:* |
| *Ethnicity:*       | *Language Spoken:*      | *Interpreter Required:* [ ]  *Yes* | *Factors affecting communication:*       |
| *Living Alone* [ ]  *Yes* [ ]  *No* | *Is Patient able to open the door?* [ ]  *Yes* [ ]  *No* | *If NO, how is the property accessible?*      |
| *Has the patient consented to the referral and to the sharing of relevant data and sensitive personal* [ ]  *Yes* [ ]  *No* | *Has the patient consented to transfer to a community bed ? (if applicable)*[ ]  *Yes* [ ]  *No* |
| ***SECTION 2 GP DETAILS*** |
| *GP Name:*       | *GP Surgery:*       |
| *GP Tel No:*       | *Practice Code:*       |

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| ***SECTION 3 REFERRER’S DETAILS*** |
| *Referrer Name:*       | *Tel:*       |
| *Organisation:*       | *Designation:*       |
| ***SECTION 4 REFERRAL DETAILS*** |
| *Presenting Complaint :* *Reason for Referral:*  |
| *Current Diagnosis/ Treatment and Significant Past Medical History (include in here any recent hospital admissions and reason for admission):*      |
| *Any Known Allergies or Adverse Reactions(GP and Hospital staff only):*  | *Current Height, Weight, BMI and BP:*  |
| *Any medication issues ?*       |
| If you know which service or team you require please tick the box below.*Frailty* [ ] *Community Beds* [ ] *Community Therapy* [ ] *District Nursing* [ ]  | [ ] INT Social Care Provision – Connect 4 Life *Please note that currently referrals to adult social services are made via the following number : 0300 123 6701* |
| ***Referral Response****:* | [ ] *Urgent* | [ ]  *Less Urgent* | [ ]  *Routine* |
| *Is there specific date or time the service is required? Please Specify here:*       |
| ***SECTION 5 SAFEGUARDING AND RISK***  |
| *Vulnerable Adult*[ ]  *Yes* [ ]  *No Double up Required:*[ ]  *Yes* [ ]  *No* |
| *Are there any known risks for the visiting staff?* [ ]  *Yes* [ ]  *No If* Yes, *Please add comments:*       |
| ***SECTION 6***  |
| ***Carer / Next of Kin / Significant Other details (if known)*** |
| *Name:*  | *Relationship to Patient:*       | *Is Family/Carer aware of referral:* [ ] Yes [ ] No |
| *Address:*       | *Postcode:*       | *Tel No:*       |
| ***Social Circumstances (if known)*** |
| *Does the patient care for somebody?*[ ]  *Yes* [ ]  *No* | *Comments:*       |
| *Is the Patient Housebound?* [ ]  *Yes* [ ]  *No* | *Comments:*       |
| *Existing Care Package?*[ ]  *Yes* [ ]  *No* | *Comments:*       |
| ***Others involved in the Patient Care*** |
| ***Health Professionals*** |
| *Name:*  | *Organisation:*       | *Contact No.*       |
| ***Social Care*** |
| *Name:*  | *Organisation:*       | *Contact No.*       |
| ***Voluntary Groups / Significant others / Other*** |
| *Name:*  | *Organisation:*       | *Contact No.*       |
| ***SECTION 7***  |
| *Expected date of Discharge? (for patients in hospital) Please Specify here:*       |
| *Pressure Areas:* *State problem, site, grade of any pressure sores and current treatment:*      |
| *Continence/Bladder Problems, please state:*      *Stoma:* [ ]  *Yes* [ ]  *No Catheter:* [ ]  *Yes* [ ]  *No To be changed by:* [ ] DN [ ] Hospital *Date of Change:*      *Reason for Catheterisation :*       *Date last Catheterised*:     *Catheter Type\*:* Urethral [ ]  Suprapubic [ ]  Intermittent [ ]  Type      *Term: Short* [ ] *Long* [ ] *Size:*       *Balloon Size:*       |
| *Dietary: Special Feeding Requirements / Swallowing Problems – state:*       |
| *Cognition : Has the patient a diagnosis of dementia ?* [ ] *Yes* [ ] *No**6 Cit Score if available?*            |
| *How does the patient mobilise:*[ ]  *Independently* [ ] *With supervision of staff* [ ] *With a Zimmer frame* [ ] *With support of staff* [ ] *With a stick* [ ] *With elbow crutches* [ ] *With crutches* [ ] *Can the patient manage stairs* [ ] *Immobile If immobile, since when?*       |
| *Please indicate if there has been sudden deterioration in functional ability:-*[ ] *Deterioration of mobility/unable to mobilise* [ ] *High risk of neglect* [ ] *Unable to transfer without assistance* [ ] *Unable to maintain nutritional needs* [ ] *Unable to access toilet unassisted* [ ] *Increase dependency during the night*[ ] *High risk of falls/recurrent falls in last 72hrs* [ ] *Increased dependency regarding personal care need*[ ] *Increased dependency regarding domestic care needs* |
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| ***Please include any other significant information here*** |
|       |

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