|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Adult Community Services** Referral form  GP Surgeries - Please email referrals to:[**lcft.MAP@nhs.net**](mailto:lcft.MAP@nhs.net) Email referrals to: [MAP@lscft.nhs.uk](mailto:MAP@lscft.nhs.uk) Tel: 01772 777 999 Fax: 01772 520 520 | | | | | | |  | | --- | |  | | |  | |  |  | |
| |  | | --- | | **All sections must be fully completed, if not known please indicate.**  **REFERRAL DATE:** | |  | | |  | |  | |  | |  |  | |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***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:* | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***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* | | | | | | | | | | | | | |  | | | | | | | | | | | | | | ***Please include any other significant information here*** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  |  | |  | |  | |  | | |