|  |
| --- |
| Guidance*This is the referral form to the Leeds Community Services.* *Section one is compulsory and must be completed.* *The following sections must be completed as appropriate to the support required.**Once this form is completed please email to: lcht.**gateway.leeds@nhs.net* |
|  |
| **COMPULSORY - Section One**  |
| **Patient Details** | Name: |       | Surname: |       |
| Gender: |       | DOB: |       |
| NHS Number: |       |  |
| Address: |       |
| **Referrer Details** | Name: |       | Designation: |       |
| Team: |       | Team Contact Number: |       |
| Team Email: |       |  |  |
| **GP details** | GP Name: |       | Practice address: |       |
| **Next of Kin details** | Name: |       | Phone Number: |       |
| **Admission Details** | Not Applicable: (Not a hospital / bed base referral) | [ ]  |
| Consultant on admission: |       | Current Consultant: |       |
| Date of admission: |       | Ward Number: |       |
| Expected date of discharge: |       |  |  |
| **Reason for referral** Including current and past medical and social history relevant to the referral**:** |       |
| **Has the patient been considered for Primary Care?** | Yes | [ ]  | No | [ ]  | N/A | [ ]  |
| **Is the patient appropriate for consideration for a community bed?** If yes, you may be contacted for further information if required | Yes | [ ]  | No | [ ]  |  |
| **Visit Request details** | Is a specific date known? | Yes**Complete A** | [ ]  | No**Complete B** | [ ]  |
| **A** | Date and time of first visit: | Date: |       | Time: |       |
| **B** | Indicative timescale for Visit to be agreed with patient? | 0-4 hrs  | [ ]  | 4-24 hrs  | [ ]  |  |
| Tomorrow AM  | [ ]  | Tomorrow PM  | [ ]  |
| Other (Please specify) |       |
| **Does the patient have mental capacity to consent?** | Yes | [ ]  | No | [ ]  |  |
| **Does the patient give consent?** | Yes | [ ]  | No | [ ]  |  |
| **Next of Kin / Carers (informal and formal) informed of discharge?** | Yes | [ ]  | No | [ ]  | N/A | [ ]  |
| **Is any support required with communication?** | Yes  | [ ]  | No  | [ ]  |  |
| If yes, provide details:  |       |
| **Are there any safeguarding concerns?** | Yes | [ ]  | No | [ ]  |  |
| **DNACPR form in place at this point in time:** | Yes | [ ]  | No | [ ]  | Not Known  | [ ]  |

|  |
| --- |
| **COMPULSORY - Section One continued** |
| **Property Access:** | Knock and wait | [ ]  | Door buzzer | [ ]  |
| Key safe | [ ]  | Location and number of key safe: |       |
| **Referral for Social care only?** | Yes  | [ ]   | No | [ ]   |
| **No requirement to complete remaining questions** | **Continue answering questions** |
| **Mobility:***Select as appropriate* | Independent | [ ]  | Supervision | [ ]  | Assistance of 1 | [ ]  |
| Assistance of 2 | [ ]  | Walking aid | [ ]  |  |
| Additional comments related to mobility:*(If required)* |       |
| **Purpose T:**Pressure risk tool | Green | [ ]  | Amber | [ ]  |
| Red | [ ]  | Not completed | [ ]  |
| **Skin integrity:** | Intact | [ ]  | Pressure Ulcer(s) | [ ]  |
| Wound | [ ]  | Not checked | [ ]  |
| **If Pressure Ulcer(s) state category and site:** |       |
| **Equipment in place at home:** | Profiling Bed | [ ]  | Foam Mattress | [ ]  | Air flow mattress | [ ]  | Pressure relieving cushion | [ ]  |
| N/A | [ ]  | Other (please specify): |       |
| **Equipment ordered and date ordered:** | Equipment Ordered |       | Date Ordered |       |
| Required for discharge? | Yes | [ ]  | No | [ ]  |
| **Patient requires support with:***Please tick all that apply*  | Therapy Needs | Yes (go to Section 2) | [ ]  | Not applicable | [ ]  |
| Catheter Care | Yes (go to Section 3) | [ ]  | Not applicable | [ ]  |
| Medication | Yes (go to Section 4) | [ ]  | Not applicable | [ ]  |
| Wound Management Care | Yes (go to Section 5) | [ ]  | Not applicable | [ ]  |
| Intravenous Care | Yes (go to Section 6) | [ ]  | Not applicable | [ ]  |
| Enteral Feeding | Yes (go to Section 7) | [ ]  | Not applicable | [ ]  |
| Tracheostomy | Yes (go to Section 8) | [ ]  | Not applicable | [ ]  |
| Bowel Care | Yes (go to Section 9) | [ ]  | Not applicable | [ ]  |

|  |
| --- |
| *The following sections must be completed as appropriate to the support required.* |
|  |
| **SECTION 2 - Therapy Needs** |
| **Exercise Tolerance** | Stair practice | [ ]  | Mobility | [ ]  | Post operation treatment plan | [ ]  |
| Fully weight bearing | [ ]  | Partial weight bearing | [ ]  | Non weight bearing | [ ]  |
| If non or partial weight bearing, is it | Left | [ ]  |  |
| Right | [ ]  |  |
| Both | [ ]  |  |
| **Other requirements:** | Support with activities of daily living | [ ]  | Wash/Dress | [ ]  |
| Kitchen assessment | [ ]  | Transfer | [ ]  |
| Seating assessment | [ ]  | Wheelchair assessment | [ ]  |
| Supplement equipment | [ ]  |  |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Next outpatient appointment:** | Insert date: |       |
| **Equipment provided :** |       |
| **Equipment ordered:** |       |
| **Additional information:** |       |
|  |
| **SECTION 3 - Catheter care** |  |
| **Type of catheter:** | 1. Urethral
 | [ ]  | 1. Suprapubic
 | [ ]  |
| 1. Intermittent
 | [ ]  | 1. Urostomy
 | [ ]  |
| 1. Nephrostomy
 | [ ]  |  |
| **Support required:** | Advice/education | [ ]  | Emptying of bag | [ ]  |
| Routine change | [ ]  | Site maintenance | [ ]  |
| Date of change: |       |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Supplementary:***(If 1 or 2)* | Safe to change in the community? | Yes | [ ]  | No | [ ]  |
| If yes, catheter care management plan sent with patient? | Yes | [ ]  | No | [ ]  |
| Trial without catheter (TWOC) | Yes | [ ]  | No | [ ]  |
| *If yes, insert date if known* |       |
| Registered with charter | Yes | [ ]  | No | [ ]  |
| **Additional information:** |       |
|  |
| **SECTION 4 – Support with Medication** |  |
| **Level of support:** | Administration | [ ]  | Prompt | [ ]  |
| Supervision | [ ]  | Teaching/Education | [ ]  |
| Symptom Management | [ ]  |  |
| **Type of medication:** | Oral from compliance | [ ]  | Oral from Packets | [ ]  |
| Enteral medication | [ ]  | Transdermal | [ ]  |
| Injectable | [ ]  | Ear/eye drops | [ ]  |
| Per rectum/vagina | [ ]  | Syringe driver | [ ]  |
| **If injectable:** | Aranesp | [ ]  | Vitamin B12 | [ ]  |
| Chemotherapy | [ ]  | Insulin (type) | [ ]  |
| Anticoagulant  | [ ]  | Midazolam | [ ]  |
| Antiemetic | [ ]  | Analgesia | [ ]  |
| GCSF | [ ]  | Hyoscine | [ ]  |
| Other:  |       |
| **Frequency:** | Once daily | [ ]  | Weekly | [ ]  |
| Twice daily | [ ]  | Monthly | [ ]  |
| Three times daily | [ ]  | 12 Weekly | [ ]  |
| Four times daily | [ ]  | Other: |       |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Additional information:** |       |
|  |
| **SECTION 5 - Wound Care Management** |
| **Type of wound:** | Surgical wound | [ ]  | Leg ulcer(s) | [ ]  |
| Pressure Ulcer(s) | [ ]  | Traumatic | [ ]  |
| Other(s): |       |
| **If surgical, sutures /clips to remove:** | Yes | [ ]  | No | [ ]  |  |
| If yes, date of removal: |       |
| **Dressings required:** | Yes | [ ]  | No | [ ]  |
| **Dressings with patient** (7 day supply) **:** | Yes  | [ ]  | No | [ ]  |
| **Frequency of dressings:** | Once daily | [ ]  | Twice a week | [ ]  |
| Twice daily | [ ]  | Three times a week | [ ]  |
| Once a week | [ ]  | Fortnightly | [ ]  |
| Other |       |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Additional information:** |       |
|  |
| **SECTION 6 - Intravenous care** |
| **Type of IV line:** | Hickman | [ ]  | PICC | [ ]  | Portacath | [ ]  |
| Other: |       |
| **Line care required:** | Medication Disconnect | [ ]  | Routine Flush | [ ]  | Site Maintenance  | [ ]  |
| **Flushing solutions with the patient:**(Seven day supply) | Yes | [ ]  | No | [ ]  |  |
| **Date Required:** |       |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Additional information:** |       |
|  |
| **SECTION 7 - Enteral feeding** |
| **Type of tube feeding:** | Gastrostomy  | [ ]  | Jejunostomy | [ ]  | Nasogastric | [ ]  |
| Naso-jejunal | [ ]  | Other (Please specify): |       |
| **Tube care required:** | Connect | [ ]  | Disconnect | [ ]  |
| Flush | [ ]  | Medications | [ ]  |
| Balloon change  | [ ]  | Balloon volume check | [ ]  |
| Tube change | [ ]  | Tube rotation | [ ]  |
| Advance and rotate | [ ]  |  |
| **Frequency:** | Once Daily | [ ]  | Twice a week | [ ]  |
| Twice Daily | [ ]  | Three times a week | [ ]  |
| Three times a day | [ ]  | Fortnightly | [ ]  |
| Four times daily | [ ]  | Every 12 Weeks | [ ]  |
| Weekly | [ ]  | Other | [ ]  |
| **Time of day:** | Day (0700-1700) | [ ]  | Night (2200-0700) | [ ]  |
| Evening (1700-2200) | [ ]  |  |
| **Level of support:** | Administration | [ ]  | Prompt | [ ]  |
| Supervision | [ ]  | Teaching/Education | [ ]  |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Regime to be sent with patient** | Yes | [ ]  | No | [ ]  |  |
| **Equipment sent** | Yes | [ ]  | No | [ ]  |
| **Referral made to Enteral feeding homecare company nurse** | Yes | [ ]  | No | [ ]  | N/A | [ ]  |
| **Additional information:** |       |
| **SECTION 8 - Tracheostomy** |
| **Level of support:** | Administration | [ ]  | Prompt | [ ]  |
| Supervision | [ ]  | Teaching/Education | [ ]  |
| **Family carer able to support?** | Yes | [ ]  | No | [ ]  |  |
| **Level of independence of patient** |       |
| **Equipment in place** | Yes | [ ]  | No | [ ]  |  |
| **Equipment sent with patient** | Yes | [ ]  | No | [ ]  |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Additional information:** |       |
|  |  |
| **SECTION 9 – Bowel Care** |
| **Type of Bowel care** | Enema - Microlax | Yes | [ ]  | No | [ ]  |
| Enema - Phosphate  | Yes | [ ]  | No | [ ]  |
| Enema - Other (Please specify): |       | Yes | [ ]  | No | [ ]  |
| Suppository | Yes | [ ]  | No | [ ]  |
| Manual/Digital Evacuation | Yes | [ ]  | No | [ ]  |
| Bowel Irrigation  | Yes | [ ]  | No | [ ]  |
| Specify details |       |
| **Frequency Required** | Detail frequency |       |
| **Medication / Equipment** | With patient? | Yes | [ ]  | No | [ ]  |
| **Family Support:** | Can Family/Carers support? | Yes | [ ]  | No | [ ]  |
| If yes, explain how |       |
| **Additional information:** |       |