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|  | **Referral Form** | **Clinical Admin Use:**HCAS No ………………………….Request recorded on S1  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of contact** |       |  | **Time of contact** |  |
|  |
| **Patient**  |
| Name |  | DOB:       |
| Current Location |       | GP       |
| **NHS NUMBER** |       |
| Address/Tel No |       |

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| --- |
| **Referrer** |
| Name |  | Designation  |  |
| Contact details |       |  |
| **SYSTMONE RECORD** – THIS PATIENT HAS GIVEN VERBAL CONSENT FOR OVERGATE TO |
| SHARE IN:  | YES | [ ]  | NO | [ ]  |  |
| SHARE OUT:  | YES | [ ]  | NO | [ ]  |  |

|  |  |
| --- | --- |
| **Diagnosis** |  |

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| **Reason for referral/contact** |
| [ ]  | **Inpatient** **admission** | **Does the patient agree to admission?****Does the patient have capacity to consent to admission?** | YES YES | [ ] [ ]  |  NO | [ ]  |  |
| **Urgency?** | Same day  | [ ]  | Next day  | [ ]  | Routine  | [ ]  |  |
|  | **Reason for admission?** | Symptom control  | [ ]  | Terminal Care  | [ ]  | Psychological support  | [ ]  | Other [ ]  |
|  | **HOOF required?** | Yes No | [ ] [ ]  | **DNAR in place?** | Yes No | [ ] [ ]  | **Infection?**  | Yes No | [ ] [ ]  |
|  | **Does the patient have any pressure damage?**  | Yes No | [ ] [ ]  | Area/s affectedGrade | [ ] [ ]  |
|  | **Does this patient smoke?**  | Yes | [ ]   | No  | [ ]  |
| [ ]  | **Day Hospice**  | [ ]  **Dementia Service – Time to Think** Pass information to a Senior Member of Day Hospice Staff |

|  |
| --- |
| **Current care arrangements/provision at home** |
| **Problems prompting referral** |  |  |
| Assessed recently by SPCT [ ]  | Life limiting illness [ ]   | Uncontrolled Pain [ ]   | Psychological/spiritual issues[ ]  | Other uncontrolled symptoms [ ]  please specify below |
|

|  |  |
| --- | --- |
| **Has this patient expressed a preferred place of death?**  |  Home [ ]  Hospice [ ]  Hospital [ ]  Nursing Home [ ]  |

**Does this patient have any specialist needs, e.g. tracheostomy, specialist equipment, spiritual, dietary, language/ interpreter? YES/NO****Details ……………………………………………………………………………………………………………………** |
| **Referral Information** |
|  |

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| **Additional Comments**     **Signed:****Date:**  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Reason for delay**  | Patient chooses to wait | [ ]  | Staffing issues at Overgate | [ ]  | Other  | [ ]  |
| No beds at Overgate | [ ]  | Transport  | [ ]  |

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| --- |
| **ADMISSION ARRANGEMENTS** |
| **Date patient to be** **admitted to Overgate** |       |
| **Above agreed by** **(Overgate Doctor)** | **Name** | **Date** | **Time** |
| **Above agreed by** **(Overgate Nurse)** | **Name** | **Date** | **Time** |
| **Admission date offered** **to referrer by:** | **Name** | **Date** | **Time** |
| *REFERRER ASKED TO:* | *INFORM PATIENT**ARRANGE TRANSPORT IF NECESSARY**ARRANGE OXYGEN IF NECESSARY* |  |  |
| **IPU Whiteboard updated** |  |  |
| **Ward Clerk informed** |  |  |
| **On Waiting List in Referral Folder** |  |  |
| **SystmOne Status updated to “on Waiting List”** |  |  |
| **Same Day Admissions only:** | **Inform Reception** |  |  |
|  | **Inform Housekeeping** |  |  |
|  | **Inform Catering** |  |  |
| **Admission arranged by ………………………………………………………..** |  |  |

Updated 06 October 2018