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| **NCL District Nurse Service Referral Form** |
| ***Please ensure you have read and understood the guidance below, before completing this form.***1. This form is to be used for **North Central London (NCL)** patients only, NCL comprises of the following ICSs – Barnet, Camden, Enfield, Haringey and Islington.
2. If you would like to discuss a potential referral, you can contact the relevant team by phone using the contact details at the end of this form.
3. Please ensure all patients self-management opportunities have been optimised as far as possible prior to referral.
4. All areas of the form must be completed to help determine what will be clinically suitable. If all areas of the form are not completed, the form may be returned for completion.
5. No further information will be required except for patients with more complex needs.
6. Please note DN Referrals will only be accepted for house bound patients. Patients who are able to visit GP surgery/Local health Clinic to access care must be referred there. Mobile Patients are expected to visit GP Surgery/ Local health Clinic.
7. Free text boxes expand so please complete forms online
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| **SECTION 1 – CONSENT** |
| Has the patient consented to this referral? No [ ]  Yes [ ] Does the patient have capacity to consent to this referral? No [ ]  Yes [ ] *IF NO*, has a MCA (Mental Capacity Act) and a best interest decision been made and documented in the patient’s notes?(a copy may be requested) No [ ]  Yes [ ]  Is the patient aware of decision?No [ ]  Yes [ ]  |
| **SECTION 1.1 – PATIENT DETAILS** |
| Name:      Telephone - Home number:       | **NHS number:**        |
| Date of birth:       Click or tap to enter a date. | Gender: Choose an item.       |
| Ethnicity: Choose an item. Specify:       |
| Address:       Postcode:       Borough: Choose an item.  |
| GP Surgery:       | NOK Name:        |
| Address:      Postcode:      GP Borough: Choose an item. | NOK Relationship: Choose an item. IF other, please specify:       |
| NOK tel. number:       |
| Language Spoken:       Is an interpreter required? No [ ]  Yes [ ]  |
| **SECTION 1.2 – REFERRAL DETAILS** |
| Current hospital:       | Name of referrer(s):       |
| Current Ward/ Department:        | Contact number(s) for further information:       |
| Ward contact no:       |
| Date of admission:  | Contact email:       |
| Date referral sent to Single Point of Access:  |
| **Reason for Referral:** [ ]  Bowel Care [ ]  Catheter Care [ ]  Continence [ ]  Stoma Care [ ]  Hickman/PICC Line Care [ ]  IV’s Medication (Note: must be discussed with a District Nurse Team) [ ]  Medication [ ]  PEG Care [ ]  Palliative Care [ ]  CHC Assessment [ ]  Pressure Ulcers [ ]  Diabetic Foot Wound [ ]  Tracheostomy [ ]  TNP (VAC Therapy) (Note: TVS Referral must be completed for ordering of the TNP pump)[ ]  Other wound care - please specify:      [ ]  Other reason for referral (if not listed) – please specify:       |
| Preferred time of first District Nurse visit:[ ]  Morning [ ]  Lunch [ ]  Afternoon [ ]  Evening [ ]  N/ASpecific time of **First** visit if applicable:       |
| **SECTION 2 MEDICAL DETAILS** |
| Discharge summary for current admission attached? (Recommended)No [ ]  Yes [ ]  IF unavailable detail reason for admission, medical intervention and post discharge plans**:**       |
| Are there any post-op instructions? Choose an item.*IF other,* *please specify*       |
| Past medical history and co-morbidities:       |
| Is the patient oxygen dependant? No [ ]  Yes [ ]  [ ]  N/ACurrent prescription of oxygen:       |
| Is the patient receiving any on-going medical intervention (e.g. dialysis)? No [ ]  Yes [ ]  [ ]  N/A *If yes, please specify*        |
| List any investigations and follow up appointments (include dates where known). Provide details:       |
| Known **Allergies?** No [ ]  Yes [ ]  Details:       |
| Is the patient currently under the palliative care team? No [ ]  Yes [ ]  N/A [ ]  Details:       |
| Resus status whilst an in-patient: DNAR [ ]  No [ ]  Yes [ ]  |
| Is the patient Covid Positive No [ ]  Yes [ ]  Have Covid symptoms No ☐ Yes ☐ |
| **SECTION 3 MOBILITY AND ADL (Activities of Daily Living)** |
| Current level of mobility: Choose an item. |
| Current level of transfer: Choose an item.*If other, please specify:*       |
| List any equipment the patient is to be discharged with:       |
| **Rockwood Frailty Score** at point of referral: [ ]   | Choose an item. |
| **SECTION 4 CONTINENCE** |
| **Bladder**  Choose an item.Is this new? No [ ]  Yes [ ]  | **Bowels**  Choose an item.Is this new? No [ ]  Yes [ ]  |
| When was the Catheter inserted? Click or tap to enter a date.Catheter Size:      Date when the next change is due? Click or tap to enter a date.Does the Patient have a Catheter Passport? No [ ]  Yes [ ] Reason for Catheter insertion? Please specify       |
| **SECTION 5 NUTRITION**  |
| Current BMI:       BMI Classification: Choose an item. Height (cm):       Weight (Kg):      *Complete the rest of this section if relevant to referral.*  |
| **Is the patient known to the Dietetics Team?** No [ ]  Yes [ ]  |
| **Does the patient have a :** PEG☐ NG tube[ ]  NJ tube [ ]  Has an NCL Enteral feeding discharge risk assessment and preparation form been completed No [ ]  Yes [ ]   |
| **SECTION 6 COMMUNICATION AND COGNITION** |
| Are there any communication needs? No [ ] Yes [ ]  *If yes*, please specify:       |
| Is there a diagnosis of dementia? Choose an item.Is there a diagnosis of delirium?Choose an item. |
| Is there evidence of cognitive impairment? No[ ]  Yes [ ]  Details:        |
| Have there been any behaviour which required specialist management, e.g. wandering, aggression, 1:1, falls, and enhanced supervision? No [ ]  Yes [ ] *If yes*, please specify:        |
| Does the patient have active mental health needs (e.g. low mood, anxiety**)?** No [ ] Yes [ ]  *If yes*, please specify:       |
| Any active safeguarding of vulnerable adults alert? No [ ] Yes [ ]  *If yes*, please specify:       |
| **SECTION 7 SKIN INTEGRITY** |
| Is skin intact? No [ ]  Yes [ ]  Waterlow Score: Choose an item. |
| *If no*, detail location of wound/s/ category of pressure ulcer:       |
| Dressing products (if required) have been supplied for 2 weeks (including dressing packs, saline and wound care products): Yes [ ]  N/A [ ]  |
| Complete a wound care plan or update the existing wound care plan: Yes [ ]  N/A [ ] **Note**: Wound assessment chart and Care Plan to be sent with patient |
| **SECTION 8 ACCESS ARRANGEMENTS (FOR DN ACCESS)**  |
| **Client can answer the door** [ ]  | **Intercom**[ ]   | **Key safe**[ ]  | **Family member to open** [ ]  |
| Further detail on access:        |
| Any known concerns regarding home environment to be addressed by community staff? For example: Pets/ Heavy Smoking - Specify:       |
| **SECTION 9 NCL DN COMPLETION GUIDANCE** |
| The following must accompany the patient on discharge:-1. **e-Prescribing and Medication Administration**
2. **Wound Care Plan + wound Assessment chart**
3. **Full Discharge Summary**
4. **Behavioural Chart (if applicable)**

**All forms will need to be sent to the DN service identified below at least 24- 48 hours before the patient is discharged. If not appropriate, the referral will be declined.** **DN Service:****Barnet:** **clcht.plannedcarebarnet@nhs.net** - **Tel:** **0300 020 0655** **Camden:** **camdenreferrals.cnwl@nhs.net** - **Tel:** **020 3317 3400****Haringey:** **haringey.adult-referrals@nhs.net** - **Te**l**: 020 3316 1600 / 24 hrs - 020 7288 3555****Islington:** rapidaccess@islington.gov.uk **- Tel: 0207 527 2179****Enfield**: **beh-tr.ECSenfieldlocalityteamsSPA@nhs.net** **– see contact below:****Monday – Friday** **08.00 – 16.30hrs** District Nursing Office: - - **Tel: 020 8702 5910** **16.30 – 08.00hrs** Royal Free Hospital ask for District Nursing Service: **Tel: 020 7794 0500.** **Weekend & Bank Holidays** 24hrs service - Royal Free Hospital ask for District Nursing Service: **Tel: 020 7794 0500****SPA:**Barnet Hospital (All Patients) **Rf-tr.discharge-team@nhs.net**Royal Free Hospital (All Patients) **RF.dischargeteam@nhs.net**Whittington hospital (All patients)  **whh-tr.dcc@nhs.net**North Middlesex hospital (All patients) **northmid.dischargeplanning@nhs.net**UCLH (All patients) **UCLH.DischargeSupport@nhs.net****All forms should be sent to the receiving DN service via email, with a read receipt which will confirm receipt of referral. Referrals sent on Friday’s will require a follow up call after 16:00pm to confirm receipt of referral.****Please do send a copy of the DN Form to your SPA for their records.**It is good practice for Referral form to be followed up with a telephone call prior to the patient leaving the ward/department to confirm care will be in place. |

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| **Outcome** | This referral has been Choose an item. | Reason, if applicable        |
| Further recommendation or alternative destination:       |
| Screener name       | Date: Click or tap to enter a date. |

**FOR TRIAGE USE ONLY**