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| **NCL D2A Pathways 2 and 3 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 CCGs – **Barnet, Camden, Enfield, Haringey and Islington**
2. All Patients should be medically optimised and safe to transfer to onward care.
3. 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.
4. Please note that patients who may present a risk to themselves or others on discharge, or for whom a safeguarding alert has been raised should always be discussed with a Clinician via the SPA before the referral is completed.
5. Free text boxes expand, so please complete forms online
6. 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.
7. Please note, section 8 is only required for in-patient care. Section 9 and 10 are for complex patients who will be managed at home.
8. No further information will be required except for patients with more complex needs.
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| **SECTION 1 – CONSENT** |
| Has the patient consented to this referral? Yes [ ]  No [ ] Does the patient have capacity to consent to this referral? Yes [ ]  No [ ] *If no*, has an MCA and a best interest decision been made and documented in the patient’s notes? Yes [ ]  No [ ]  (a copy may be requested)Is the patient aware of decision? Yes [ ]  No [ ] Is the family/carer aware of the decision? Yes [ ]  No [ ]  |
| **SECTION 1.1 – PATIENT DETAILS** |
| Name:      Telephone number (at home):       | NHS number:        |
| Date of birth:       | Gender: Choose an item.       |
| Address:       Postcode:       Borough: Choose an item.  |
| GP name:       | NOK name:        |
| GP address:      GP postcode:      GP Borough: Choose an item. | NOK Relationship: Choose an item. If other, please specify:       |
| NOK tel. number:       |
| Language Spoken:       |
| **SECTION 1.2 – REFERRER DETAILS** |
| Current hospital:       | Name of referrer(s):       |
| Current ward:        | Contact number(s) for further information:       |
| Ward contact no:       |
| Date of admission:        | Contact email:       |
| Date referral sent to SPA:       |
| Reason for referral: Choose an item.If Pathway 2, include identified rehab goals:       |
| **SECTION 2 MEDICAL DETAILS** |
| Give reason for current admission:      Detail current medical status:       *Or if discharge summary to-date is available, please attach*  |
| Are there any post-op instructions? Yes [ ]  No [ ]  *If yes,* please specify       |
| Past medical history and co-morbidities:       |
| Is the patient oxygen dependant? Yes [ ]  No [ ] Current prescription of oxygen:       |
| Is the patient receiving any on-going medical intervention (e.g. dialysis)? Yes [ ]  No [ ] *If yes,* please specify:       |
| Does the patient have any planned post discharge investigations or follow up appointments?Yes [ ]  No [ ]  Details       |
| Known allergies? Yes [ ]  No [ ]  Details:      |
| Is the patient currently under the palliative care team? Yes [ ]  No [ ]  Details:      |
| Resus status whilst an in-patient: CPR [ ]  DNACPR[ ]   |
| **SECTION 3 – MOBILITY**  |
| Weight bearing status  | Choose an item.NWB? Yes [ ]  No [ ]  If Yes, how long?       Is hoist required? Yes [ ]  No [ ] Fracture Clinic appointment (if known): Click or tap to enter a date.  |
| Current level of mobility and transfers: Day       Night       |
| List any equipment the patient is to be discharged with:       |
| Is bariatric equipment required?        |
| Current level of ability in personal care:       |
| Summarise known preadmission mobility, transfers and ADL information:       |
| Has the patient been involved with Rehab on the acute ward? Yes [ ]  No [ ]  |
| Rockwood Frailty Score, at point of referral:  | Frailty Score: Choose an item. |
| **SECTION 4 – CONTINENCE** |
| **Bladder** Choose an item.Is this new? Yes [ ]  No [ ]  | **Bowels**Choose an item.Is this new? Yes [ ]  No [ ]  [ ]  |
| **SECTION 5 – COMMUNICATION AND COGNITION** |
| Are there any communication needs? Yes [ ]  No [ ]  *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? Yes [ ]  No [ ] Details:      *If available*, please include any screening assessment scores:       |
| Has there been any behaviour which required specialist management, e.g. wandering, impulsive behaviour, aggression, and falls? Yes [ ]  No [ ] Please specify previous/current management e.g. 1:1 and enhanced supervision        |
| Can the patient call for help and wait for a carer to respond day and night?  |
| Can the patient be left alone at night? Yes [ ]  No [ ]  |
| Can the patient be left alone in a flat between carer visits? Yes [ ]  No [ ]  |
| Is the patient currently under a DOLS? Yes [ ]  No [ ]  |
| Does the patient have active mental health needs (e.g. low mood, anxiety)? Yes [ ]  No [ ] *If yes,* please specify:       |
| Any active safeguarding of vulnerable adults alert? Yes [ ]  No [ ]  I*f yes*, please specify:       |
| **SECTION 6 – SKIN INTEGRITY** |
| Is skin intact? Yes [ ]  No [ ]  Waterlow Score: Choose an item. |
| *If no*, detail site/ category of ulcers:       |
| *If no*, complete the wound care plan or include the existing wound care       |
| Has a Community Nurse referral been made? Yes [ ]  No [ ] *If yes*, Choose an item.*If yes,* p*lease specify reasons:*       |
| **SECTION 7 – NUTRITION (eating and drinking)** |
| Diet intake route:Choose an item. | Type:Choose an item. | Diet Preferences:Choose an item. | Other:       |
| Fluid intake route:Choose an item. | Type:Choose an item. | Additional info: Choose an item. | Other:       |
| **If patient is being risk fed, discuss with referring ward prior to patient transfer** |
| Height (cm):       Weight (Kg):       Current BMI       BMI Classification: Choose an item. |
| **SECTION 8 – INTER-HEALTHCARE INFECTION CONTROL (Not required for patients going home – see section 9-10)** |
| Does patient have an alert organism? Yes [ ]  No [ ] *If yes*, please state alert organism in relevant specimens box below and attach relevant lab report:       |
| Patient recently exposed to others with known / suspected infection, e.g. Norovirus, Influenza, CPE/CRO/CRE/ CPO/OTHER? Yes [ ]  No [ ]  Please give details:       |
| *If yes* to: Influenza/Flu; more than 72 hours since the exposure and prophylaxis given/started? Yes [ ]  No [ ] Norovirus: More than 48 hours symptom free? Yes [ ]  No [ ]  |
| Does the patient have diarrhoea? Yes [ ]  No [ ]  If the patient has diarrhoeal illness, please attach a copy of bowel history for the last week (Bristol Stool Scale). Copy attached? Yes [ ]  No [ ] Is the diarrhoea thought to be of an infectious nature? Yes [ ]  No [ ]  Comments i.e. history of bowel disease, laxative use etc.:       |
| Relevant significant specimen results (including any MRSA, CPE, CPO, CRO, CRE, ESBL stool screening) and treatment information, including antibiotics given:       |
| **Specimen** |  |  |  |  |
| **Date**  |  |  |  |  |
| **Result**  |  |  |  |  |
| **Treatment**  |  |  |  |  |
| Other relevant information:       |
| Does patient have invasive devices such as urinary catheters, PICC lines, Venflons etc.? Yes [ ]  No [ ] *If yes,* please specify device, size, and date of insertion:                                       Does patient have a catheter passport? Yes [ ]  No [ ]  |
| Does the client require isolation upon transfer? Yes [ ]  No [ ] **Once the receiving unit has been confirmed, contact will be made to discuss the rationale for isolation.**  |
| ***If planned care is at home, please complete section 9 and 10*** |
| **SECTION 9 – ANTICIPATED SUPPORT NEEDS/CARE AT HOME** |
| Is there an existing care package? Yes ☐ No ☐ Don’t Know [ ]  |
| Package of care anticipated Yes [ ]  No [ ]  Don’t Know [ ] (based on current needs in hospital – POC will be finalised at home assessment)  |
| Time: Morning [ ]  Lunch [ ]  Teatime [ ]  Evening[ ] Anticipated care needs:       |
| **SECTION 10 – HOME ACCESS ARRANGEMENTS (Community Assessor )** |
| Client can answer the door [ ]  | Intercom [ ]  | Keysafe [ ]   | Family member to open [ ]  |
| Further detail on access:       |
| Any known concerns regarding home environment (for example pets) to be addressed by community staff?       |
| Social factors that may impact upon the patient being discharged home (social issues, deep cleans, renovations, etc.? |
| Other information Community Staff should know prior to first visit? (e.g. Any cognitive impairment identified, resolving delirium, behavioural concerns, risks to lone workers, service user preferences)  |

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| **SECTION 11 – NCL D2A REFERRAL FORM COMPLETION GUIDANCE** |
| **Please note, all areas of the form MUST be completed.****The following must accompany the patient on discharge:**1. **Discharge Summary**
2. **Electronic Prescription Record**
3. **Any essential information (if, applicable)**
4. **Copy of MCA/Best Interest**
5. **Behavioural chart**
6. **Food chart**
7. **Wound care plan**
8. **Bristol Stool chart**

**Essential information to be shared with patients prior to re-start:**1. **Patients need to be flexible about exact timing of any calls before 09:00 or after 21:00, while they are fitting back into care rota.**

**The form MUST be sent to the Borough SPA and copied to your appropriate hospital team below:****Speak to or send completed form to either:*** **clcht.plannedcarebarnet@nhs.net** **/ 0300 020 0655** [Barnet residents]
* **camdenreferrals.cnwl@nhs.net** **/ 07714 597309** [Camden residents]
* **chasefarmbedmanager@nhs.net** [Enfield-Pathway 2 - ]
* **Beh-tr.MagnoliaUnit@nhs.net**/ **0208 702 5690** for Rehab Referrals [Enfield Residents]
* **Enfccg.discharge2assess@nhs.net**/ **0203 688 2174** or D2A Assessor **07508 640 353** [Enfield-Pathway 3]
* **haringeysinglepointofaccess@haringey.gcsx.gov.uk** **/ 020 8489 1616** [Haringey residents or people with a Haringey GP]
* **SPOA@islington.gcsx.gov.uk** **/ 020 7527 8087** [Islington residents]

**For telephone referrals, SPA will acknowledge receipt by emailing completed form back to referrer (see section 1.2) and copying to relevant hospital team below.*** **Rf-tr.discharge-team@nhs.net**[Barnet Hospital – All patients]
* **rf.dischargeteam@nhs.net**[Royal Free Hospital – All patients]
* **UCLH.DischargeSupport@nhs.net** [UCLH - All patients]
* **whh-tr.socialservicesreferrals@nhs.net**[Whittington hospital – All patients]
* **northmid.dischargeplanning@nhs.net** [North Middlesex hospital – All patients]

All forms to be sent between secure email accounts**FOR SPA USE ONLY** |

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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. |