BUTLER GREEN IV TEAM

SDEC AND A&E REFERRAL FORM

NHS
Northern Care Alliance
NHS Group

Salford | Oldham | Bury | Rochdale | North Manchester

SERVICE REQUIRED	AMBULATORY CLINIC:	DOMCILARY VISIT:

Patient's Name: **Address:** **Postcode:** **Telephone:**		**Next of Kin:** **Relationship:** **Address:** **Telephone:**	
Date of Birth:	**NHS Number:**	**Religion:**	**Occupation:**
GP Surgery:		**TEL:** **P Code:** ***(IV TEAM WILL COMPLETE)***	
Referring Consultant:		**Department / Hospital:** **WARD:** **TEL:**	
Specific Diagnosis and reason for referral: **PLEASE STATE EXACTLY THE CONDITION TO BE TREATED AND LOCATION ON PATIENT'S BODY**		**Past Medical History:**	
DNAR IN PLACE?	**YES** **NO**	**ALLERGIES:** **Type of reaction:**	
Microbiologist Led Treatment plan?	**YES** **NO**	**Name and contact details:**	
Microbiology Results Available? **If yes please give details.**	**YES** **NO**	**Details:**	
Does patient require a review at the end of treatment?	**YES** **NO**	**DATE REQUIRED**	**OPA** **GP** **Nurse prescriber**
Peripheral cannula in place?	**YES** **NO**	**Date of insertion:**	

Antibiotics will be discontinued on completion of prescribed treatment unless otherwise stated

Other Prescribed Medication?	**YES**	**NO**	**Oral antibiotics prescribed concurrently with IV's?** **Details:**
Required oral switch medication prescribed once IV treatment plan complete:	**YES**	**NO**	**Details:**
Blood monitoring required:	**YES**	**NO**	**Details:**

PRESCRIPTION of TREATMENT PLAN 1st DRUG

Date of 1st dose given in hospital:	**Date of 1st dose to be given by IV team:**
Date of Last dose to be given by Community IV team:	

MEDICATION	DOSE	DILUENT	INFUSION FLUID	FREQUENCY AND ROUTE

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Referral Criteria Checklist		
Patient is over 18 years of age?	**YES**	**NO**
Patient lives in Oldham / has Oldham GP?	**YES**	**NO**
Patient has capacity to consent to procedure?	**YES**	**NO**
Antibiotic is for up to 3 times daily? **(If 4 times daily consider change of antibiotic or inpatient bed at Butler Green)**	**YES**	**NO**
Patient has access to non-public transport? **(If no then not suitable for clinic.)**	**YES**	**NO**
Patient is a known IVDU **(If yes refer to IV team to discuss)**	**YES**	**NO**
If answer is shaded discuss with IV team		

IV Referrals – Treatment Plan Clinical Responsibility

(Referring consultant/team remains responsible for monitoring and reviewing the patient, blood results and complications with access line during the course of their treatment)

Consultant: Department: Contact Number:	
Consultants Secretary's Name / Email Address / Contact Number	
Blood monitoring required: Weekly bloods will automatically be taken for FBC, U & E and CRP. U & E required on 4th day Teicoplanin and Pre-dose Teicoplanin trough levels from 7 days. FBC, LFT, CRP and CK levels if on Daptomycin. These will require reviewing by referring team.	
I agree that I will take clinical responsibility for the above named patient for the duration of their treatment on IV antibiotics including reviewing any blood monitoring, problems with the central venous access line and removal of the line at the end of treatment.	Consultant's signature: Date:

Please **complete all sections** and email to copy Please attach a copy of discharge summary with the referral
Contact Number: 0161 206 0442
IV Mobile for advice: 07566766209. oldhamintegrated.dchub@nca.nhs.uk