**THE NORTH EAST SECTOR TRUSTED ASSESSMENT REFERRAL FORM**

It is MANDATORY to complete all domains of this form. Failure to complete fully may delay patients discharge. Do not use ABBREVIATIONS in support of accurate and quality recording.

**Section One: Patient Information**

|  |  |  |
| --- | --- | --- |
| Patient Name:Preferred Name: | D.O.B: | NHS No. |
| Address: | Tel No. |
| Date MOAT | EDD |
| First Language: | Ethnicity:  |
| Interpreter or communication support required?Wears glasses? Hearing aid? | Religion:  |
| Consultant: |
| DNAR in place Y/N |
| Does patient live alone? | Yes |  | No |  | Comments: |
| Pets? | Yes |  | No |  |
| ACCESS TO PROPERTY:e.g. keys safe in situ?Code: | Any known concerns for a professional to enter your home? Y/N |
| If yes please state why: |

**Consent**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has patient consented to this referral? | **Yes**  |  | **No** |  |
| If **NO** please provide further details;  |

**GP Details**

|  |  |
| --- | --- |
| Name: | Address: |

**NoK Details/Emergency Contact**

|  |  |
| --- | --- |
| Name: | Telephone: |
| Address: | Relationship: |

**Section One: Hospital Inpatient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Site: | Ward | Tel No: | Date of Admission: |
| Summary of current episode / investigations / diagnosis / ongoing treatment plans |
|  |
| PMH |
| Can patient manage their medication regime independently? | **Yes** |  | **No** |  |
| Please indicate which of the following attached: GP summary □ TTO’s □ Discharge Summary □ New additional medication? Y/NMedication with patient? Y/N |
| Who will support this on discharge? |
| Blister pack?  | **Yes** |  | **No** |  | Original Packets  | **Yes** |  | **No** |  |
| Controlled Drugs?  | **Yes** |  | **No** |  | Frequency  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Identified Safeguarding concerns | **Yes** |  | **No** |  | Comments: |
| Any identified risks in visiting patient at home | **Yes** |  | **No** |  | Comments: |
| Assistive technology | **Yes** |  | **No** |  | Comments:  |
| Referral date to reablement:  |
| Referrals to other services | District Nurses  |
| Falls Team | SALT |
| Continence Services | Other (please state) |

**Recommended Service Provision: OLDHAM ONLY**

|  |  |
| --- | --- |
| **ORCAT: Complete Section Two** | **Reablement @ Home: Complete Section Three** |
| **IMC (Butler Green): Complete Section Four** | **Reablement (Medlock Court): Complete Section Four** |

**Section Two: ORCAT Referrals**

**Baseline Observations: Taken on day of referral**

|  |  |
| --- | --- |
| **Mandatory** | **As Required** |
| BP | Temp | SPo2 | Pulse | RR | NEWS | Blood Sugars | Urine Analysis |
|  |  |  |  |  |  |  |  |

**Functional Ability: Assessed on day of referral. If none assessed please state why**

|  |  |  |
| --- | --- | --- |
| **NORMAL** | **TASK** | **CURRENT** |
|  | On/Off bed |  |
|  | Sit to stand |  |
|  | Walking |  |
|  | Stairs |  |
| History of falls? Yes/No | If yes details: |
| Risk of falls? Yes/No | If yes details: |
| Reasons for referral: |