**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/N  Medication 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: | | |