Community Step Up Referral

Community Enhanced Intermediate Care Service
REFERRAL FORM

All sections must be completed

Patient Details			
AFFIX PATIENT STICKER **or** record name, address, DOB and NHS No.		Patients Telephone No.	
		Is home the final discharge destination after a period of intermediate care? YES NO	
Ward	Ward Tel No.	Long term discharge plan:	
Religion	Marital Status	Ethnicity	Preferred Language
Interpreter Required		YES NO	
NEXT OF KIN DETAILS		**MAIN CARER (If different from NOK)**	
Full Name	Relationship to patient	Full Name	Relationship to patient
Address (including postcode)		Address (including postcode)	
Contact Tel/Mob Number(s)		Contact Tel/Mob Number(s)	
GP DETAILS			
AFFIX GP STICKER HERE **or** Record GP's details (including postcode)		Date last seen by GP	
GP Tel No.			
Qualified OT/Physio Professional:			
REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

PATIENT DETAILS	
Condition change – why IMC is required?	
Past medical history (include dates)	
WOUNDS PRESSURE ULCERS YES NO LOCATION GRADE	Equipment needed e.g. mattress/dressings Oxygen concentrator required? YES NO
Waterlow score	Weight (approx.)
Continence management	Night time needs
Physio Update	Social Worker Update
	Social Worker Name: Social Worker Tel No:

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Tameside and Glossop Integrated Care NHS Foundation Trust

Patient Name…….. DOB…… NHS No……..

CURRENT MENTAL STATE. MUST complete abbreviated mini mental test. This does not necessarily exclude patients but will support patient safety			
1. What is your age?	2. What time is it to the nearest hour?	3. Give patient the address: 42 West Street to remember ask at end of test.	4. What year is it?
5. Name of hospital	6. Recognise 2 people e.g. Doctor or Nurse	7. D.O.B	8. Dates of world war (1939 – 1945)
9. Name of Prime Minister?	10. Count backwards from 20 to 1	11. Ask the patient to repeat the address in Q3	Total Score **/10**

BEHAVIOUR		
Any signs of confusion?	YES NO	
Able to follow instructions?	YES NO	
Does the patient wander?	YES NO	
Does the patient have insight?	YES NO	
Is the patient motivated?	YES NO	
Does the patient have any challenging behaviour?	YES NO	If yes, please describe what and how is this managed?
Is the mental health team involved?	YES NO	
Is/has the patient been on DoL's	YES NO	
Any other supporting information?	YES NO	

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

Function	Previous	Current
MOBILITY Include equipment used		
STAIRS		
TRANSFERS: • BED • CHAIR • TOILET		
WASHING & DRESSING		
EATING/DRINKING		
MEAL PREPARATION		
SHOPPING/CLEANING/LAUNDRY		
CARE PACKAGE (please include any changes to care package and who will be arranging this)		

REHAB / RECOUP GOALS

REFERRERS DETAILS

NAME	SIGNATURE	DESIGNATION	DATE

Everyone Matters

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Patient Name…….. DOB…… NHS No……..

MEDICATION LIST		
Name	**Dose**	**Time of day**

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

Consent for transfer to Intermediate Care

Please sign below to confirm that you agree to completion and consideration of referral for Intermediate Care.

Patients Signature ……..

Print Name ……...

Date ……

NOK Signature ……..

Print Name …….

Date ……

Note: If NOK is unable to sign – please state if discussed with them.

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