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Waltham Forest Adult Community Health Services referral form

This top section must be completed in full or the referral will be rejected								
Surname:	Enter surname	**First Name(s):**	Enter first name	☐ **Male**	☐ **Female**			
Date of Birth:	Click here to enter a date.	**NHS No.**	Enter NHS no.	**Hospital No**:	Enter Hospital no.			
Ethnicity (please tick relevant box)	*White:*	☐ British	☐ Irish	☐ Any other White background				
	Mixed:	☐ White & Black Caribbean	☐ White & Black African	☐ White & Asian	☐ Any other mixed background			
	Asian or Asian British:	☐ Indian	☐ Pakistani	☐ Bangladeshi	☐ Any other Asian background			
	Black or Black British:	☐ Caribbean	☐ African	☐ Any other Black background				
	Other Ethnic Groups:	☐ Chinese	☐ Any other ethnic group	☐ Ethnicity not stated				
Current Home Address	Enter patient's address	**GP Name**	Enter GP's name					
		GP Address	Enter GP's address					
Post code:	Enter patient's postcode	Post code:	Enter GP's postcode					
Phone:	Enter patient's phone number	Phone:	Enter GP's phone number					
Mobile:	Enter patient's mobile number	Mobile:	Enter GP's mobile number					
Is this address home permanent or temporary?	☐ Permanent	☐ Temporary						
Primary Language Spoken:	Click here to enter text.	**Interpreter Required:**	☐ Yes	☐ No				
Is the Patient Housebound?	☐ Yes	☐ No	**Does patient require Hospital Transport**	☐ Yes	☐ No	☐ NA		
Has this referral been discussed with and agreed by the patient?	☐ Yes	☐ No						

Indicate reason for referral and which function(s) you are referring your patient to

Reason for referral (s)

Referral will be delayed if this section is incomplete or if reason for referral does not relate to all functions selected below. Please include therapy goals, past treatments and history of presenting problem where relevant.

Click here to enter text.

Unplanned Care	☒ Rapid Response Service (admission avoidance & urgent care) ☒ OPAT IV Therapy

Planned Care

(please tick below function (s) and the input required for each function)

District Nursing /function Urgency of response required: ☐ Response expected within 24 to 48 hrs) ☐ Response expected within 3 to 5 days ☐ Palliative /End of life Care		**☐ Therapy Rehabilitation Service** ***Please tick the specific service below*** - ☐WF rehabilitation unit (Ainslie) - ☐Falls Prevention - ☐Community Rehabilitation Team		**☐ Community Matrons/Case Management & Therapy** **☐ Specialist Palliative/End Of Life Care** **☐ Tissue Viability Service**
Waterlow Score:	Click here to enter text.	Risk score if known:	Click here to enter text.	**☐ Podiatry** **☐ Continence Service** **☐ Nutrition and Dietetics**
☐ Diabetes / Education*: Diagnosed in last 12 months Must complete BMI, Chol, HbA1c, BP on page 2 ** Include copy of blood results (HbA1c, U&E and LFT), medication list and medical history**		**Community Respiratory Team** ☐ Pulmonary Rehab (PR) ☐ COPD Home support ☐ Spirometry ☐ Baseline FEV1 ☐ Asthma Care		***Specialist services*** **☐ Parkinson's** **☐ Multiple Sclerosis** **☐ Haemoglobinopathy**

Name of Referrer:	**Date of Referral:**	**Phone/Mobile:**		
	Click here to enter a date.	Click here to enter text.		
Profession/Job Title:	**Organisation / Hospital / Ward:**	Additional reports attached:	☐ Yes	☐ No
Click here to enter text.	Click here to enter text.			

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Next of Kin / Person to Contact:	Click here to enter text.		
Relationship:	Click here to enter text.	Phone Number/s:	Click here to enter text.

Relevant Medical History (diagnosis, recent illness, recent hospital admissions, investigations/results, Long Term Condition). ☐ If not relevant to this referral, please tick

Please attach summary of medical history:
Click here to enter text.

Height :	Weight:	BMI:	BP:	Chol:	HbA1c:	FEV1/FVC:	eGFR:
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Current Medication (include mode of administration /difficulties in taking)
Please attach Medication list

Click here to enter text.

☐ **No drug allergies**
☐ **No known drug allergies**
☐ **Allergies (enter below)**

Click here to enter text.

(Ensure full details of medications being authorised for DN's to administer are listed as attached 'authorisation to administer form'

Authorising signature
(Please type)
Name of GP/Medical practitioner who is authorising district nurses to administer medication
Note separate authorisation to administer form must be completed

XClick here to enter text._____

If applicable, recent Hospital admission	**Date of Admission** Click here to enter a date.	**Date of Discharge**	Click here to enter a date.
Details of Equipment / Dressings	Click here to enter text.	Details of Care Package	Click here to enter text.
Other relevant discharge information	Click here to enter text.		

Health, Social Issues and Risks
(e.g. functional/mobility problems, communication, confusion, memory loss, nutrition/diet, hearing, vision, mental health, bed bound)

Click here to enter text.

Smoker?	☐ Yes	☐ No	Consumes Alcohol?	☐ Yes	☐ No	Risk of falls?	☐ Yes	☐ No
Does patient live alone?	☐ Yes	☐ No	Risks to patient or person visiting?				☐ Yes	☐ No
Is person being cared for?	☐ Yes	☐ No	*Details if yes*	Click here to enter text.				
Key Safe Number	☐ Yes ☐ No Click here to enter text.		Key Holder Name	Click here to enter text.		Key Holder Phone	Click here to enter text.	
Is patient known to Social Services?	☐ Yes	☐ No	Contact details of social worker/care manager	Click here to enter text.				

Services / Support currently being received (details and contact names/numbers)
(e.g. personal care, community nurse, community matron, day centre, mental health, Community Rehab/Falls Team, consultant)

Click here to enter text.

Please send referrals at least 24-48hrs before the patient requires a visit, particularly if medication administration is required.
Send referral to Waltham Forest CHS Adults Service (08.00 until 17.00 Monday to Friday)
Please email all completed referral forms whenever possible

Email: nem-tr.wfadultchsreferrals@nhs.net **Phone**: 0300 300 1710

SPA triage use only		
☐ Urgent (RRT) same day response	☐ Response 24 to 48 hours of referral	☐ Response 3 to 5 days of referral
Comments		
Name	Signature	Date