

**REFERRAL TO THE DISTRICT NURSING SERVICE**

**Please complete this form and email to the relevant District Nursing HUB if the patient is unable to access their GP practice, ambulatory care or other clinics.**

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| **Any known current or previous infection control issues** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | **YES** | **NO** |
| **If Yes please give details so that community staff can be prepared for home visiting PPE requirements: -** | | | | | | | | | | | | | | | | | | |
| **MRSA STATUS** | | | | | | | | | | | | | | | | | | |
| **Positive +ve** | | | Yes  No | | | | | | | **Negative -ve** | | | | | | Yes  No | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | |
| Surname |  | | | | | | | First Name | | | | |  | | | | | |
| NHS Nº. |  | | | | | | | D.O.B. | | | | | Click here to enter a date. | | | | | |
| Gender | Male  Female | | | | | | | Ethnicity | | | | |  | | | | | |
| Home  Address  Key Code |  | | | | | | | Discharge  Address  (if different) | | | | |  | | | | | |
| Tel. Nº. |  | | | | | | | Tel. Nº. | | | | |  | | | | | |
| Next of Kin details | Name | | | | |  | | | | | | | | | | | | |
| Relationship |  | | | | | | | Tel. Nº. | | | | |  | | | | | |
| GP Practice |  | | | | | | | GP Name | | | | |  | | | | | |
| **REFERRERS DETAILS** | | | | | | | | | | | | | | | | | | |
| Referrers Name | | | | |  | | Designation | | | | |  | | | | | | |
| Referrer’s Tel. Nº. | | | | |  | | Location of referrer | | | | |  | | | | | | |
| Current location of patient | | | | |  | | Date of referral | | | | | **09/04/2024** | | | | | | |
| Other contact for referrer | | | | |  | | Time of referral | | | | | 09:55 | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | | | | | | | | | | |
| Reason for referral to DN team | | | | | | | | | | | | | | | | | | |
| **PLEASE NOTE THE DN HUB MUST BE TELEPHONED IF A VISIT IS REQUIRED ON THE DAY OF DISCHARGE:** | | | | | | | | | | | | | | | | | | |
| Reason for admission to hospital (if referrer in hospital setting) | | | | | | | | | | | | | | | | | | |
| Hospital Admission Date | | | | Click here to enter a date. | | | Hospital Discharge Date | | | | | | | | Click here to enter a date. | | | |
| **FURTHER RELEVANT INFORMATION** | | | | | | | | | | | | | | | | | | |
| **Does the patient have a urinary catheter?** Yes  No  If yes what is the reason for catheter insertion: (i.e urinary retention)  Is catheter supra-pubic  or urethral  What is the size and make of the catheter?  When was catheter last changed if known? Click here to enter a date.  When is catheter due to be replaced if known? Click here to enter a date.  Do they have a catheter passport? Yes  No  Is it appropriate for the catheter to be replaced in the community? Yes  No  Does the GP discharge information include supplies to be ordered? Yes  No  Is the patient independent with catheter care Yes  No  If NO who assists the patient with their catheter care?  Is the patient suitable to have a TWOC (Trial Without Catheter)? Yes  No  If yes has the patient been given an appointment to attend an Outpatients clinic? Yes  No | | | | | | | | | | | | | | | | | | |
| **Does the patient require support with Insulin administration?** Yes  No  Name of prescriber Contact details  Has the patient been reviewed by the diabetes specialist team during this hospital admission? Yes  No  Type of insulin: Dose of insulin:  Frequency/regime of insulin: click here to enter frequency Time of administration: Click here to enter a time  Has there been a change to their insulin regime on this admission? Yes  No  Do they have an insulin passport? Yes  No  Do they have a community insulin (green) MAR chart? Yes  No  Please ensure MAR and MEDS sent home with patient | | | | | | | | | | | | | | | | | | |
| **Does the patient require medication administration by DN, such as injection administration or eye drop instillation?** Yes  No  Name of prescriber Contact details  Is a MAR community (purple) MAR chart being sent home with patient? Yes  No  Name of medication: Frequency of medication:  When was last dose given: Click here to enter a date. What time was the last dose given  When is next dose due: Click here to enter a date.  Are the injection/drops being sent with the patient: Yes  No  Do they have a sharps box: Yes  No | | | | | | | | | | | | | | | | | | |
| **Does the patient require wound care by the DN team?** Yes  No  Has the patient been reviewed by the TVN team? Yes  No  The location of the wound:  The type/cause of the wound:  Does the patient have a wound care plan being sent home with them? Yes  No  When was the wound last redressed? Click here to enter a date.  When is the next dressing due? Click here to enter a date.  Have they been sent with 3 dressing changes? Yes  No  If the wound is the consequence of pressure damage has grade II (and above) been reported? Yes  No  Does the patient require compression therapy? Yes  No  If the patient is being sent home with VAC therapy, has this been approved by [**TVN@SomersetFT.nhs.uk**](mailto:TVN@SomersetFT.nhs.uk) Yes  No  Please ensure the wound/Leg Ulcer Assessment care plan and VAC canisters are sent home with patient. | | | | | | | | | | | | | | | | | | |
| **Does the patient require EOL care?** Yes  No  Please advise the terminal diagnosis:  Has CHC Fast Track funding been applied for? Yes  No  If yes has this been approved? Yes  No  Do they wish to have a care package? Yes  No  If yes what is the name of the care agency?  Have JIC meds been issued to the patient to take home? Yes  No  Do they have a community palliative (white booklet) and MAR chart being sent home? Yes  No  Has a referral been made to the community palliative care team (hospice)? Yes  No  **Discussing the option of carer training at the point of provision of JIC meds.**  Has the option of carer training at the point of provision of JIC meds been discussed? Yes  No  Has a conversation been had about carer training in JIC meds with the carer? Yes  No  Name and contact details of the carer:  Would the carer like to receive training in JIC meds? Yes  No  Is the carer already trained in JIC meds? Yes  No  Date of training and contact details of trainer: | | | | | | | | | | | | | | | | | | |
| **Does the patient require an INR/Point of care blood test** Yes  No  Date of **Last** INR/Point Of Care test: Click enter a date. Date of **Next** INR/Point Of Care test result: Click enter a date.  Current Warfarin dose: | | | | | | | | | | | | | | | | | | |
| **Does the patient require CVAD/IVAD care?** Yes  No  Please advise the current diagnosis:  Are they able to attend ambulatory clinic for this care? Yes  No  If yes has an appointment been booked for them if yes Click here to enter a date.  Time of appointment?  If IV therapy required what is the regime?  Name of drug going through:  Duration of treatment?  Bolus regime Yes  No  Pump regime Yes  No  If pro-forma drug chart not appropriate is MAR (purple) being sent with patient Yes  No  **IF THE REFERRAL IS FOR IV ANTIBIOTICS YOU MUST CALL THE DN HUB FIRST TO AGREE THIS TREATMENT** | | | | | | | | | | | | | | | | | | |
| **RELEVANT MEDICAL INFORMATION / MEDICATION / ALLERGIES** | | | | | | | | | | | | | | | | | | |
| DATE | | PROBLEM | | | | | | | ASSOCIATED TEXT | | | | | | | | | |
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| **KNOWN RISKS**  *(Are there any known safeguarding issues or risks for nursing staff making a first visit?)* | | | | | | | | | | | | | | | | | | |
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| **STEP ESCALATION PLAN** | | | | | | | | | | | **WITH PATIENT?** | | | Yes  No | | | | |
| **DISCHARGE SUMMARY** | | | | | | | | | | | **WITH PATIENT?** | | | Yes  No | | | | |

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| **Neighbourhood** | **Telephone** | **E-mail:** |
| Bridgwater Bay and North Sedgmoor Neighbourhood | 0300 124 5601  0300 124 5605 | [SPASedgemoor@somersetFT.nhs.uk](mailto:SPASedgemoor@somersetFT.nhs.uk) |
| Mendip Neighbourhood | 0300 124 5602  0300 124 5604 | [MendipDNReferral@somersetFT.nhs.uk](mailto:MendipDNReferral@somersetFT.nhs.uk) |
| South Somerset Neighbourhood | 0300 124 5600  0300 124 5603 | [SouthSomersetReferral@somersetFT.nhs.uk](mailto:SouthSomersetReferral@somersetFT.nhs.uk) |
| Taunton and West Somerset Federation Neighbourhood | 0300 124 5606 | [SPATauntonandwestsomerset@somersetFT.nhs.uk](mailto:SPATauntonandwestsomerset@somersetFT.nhs.uk) |