

**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 AddressKey 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 timeHas 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 givenWhen 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** 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 [x] 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 56010300 124 5605 | SPASedgemoor@somersetFT.nhs.uk |
| Mendip Neighbourhood | 0300 124 56020300 124 5604 | MendipDNReferral@somersetFT.nhs.uk |
| South Somerset Neighbourhood | 0300 124 56000300 124 5603 | SouthSomersetReferral@somersetFT.nhs.uk |
| Taunton and West Somerset Federation Neighbourhood | 0300 124 5606 | SPATauntonandwestsomerset@somersetFT.nhs.uk |