**NHS@home service referral Form/ Handover**

**STEP DOWN& STEP UP**

Referrals will be screened within 2 hours of receipt between 8am and 6pm 7 days per week, any referrals received after 6pm will not be screened until 8am the next day, we will contact you to confirm acceptance or rejection of the referral.

**NOTE if referral made after midday first visit will be tomorrow at earliest.**

Please note the patient will be on-boarded to the Doccla virtual observation monitoring platform, in addition to the phone and visiting support.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient Demographics** | | | | | | |
| Patient Name |  | | | | | |
| DOB |  | | | | | |
| Address |  | | | | | |
| NHS Number |  | | | | | |
| Email address |  | | | | | |
| **Tel No.** | **Home**: | | | | | **Mobile**: |
| PLEASE CONFIRM CONTACT DETAILS ARE CORRECT WITH PATIENT | | | | | | |
| **Next of Kin** | **Name & relationship:** | | | | | **Tel:** |
| **Consent** | | | | | | |
| Has the patient agreed to this referral? Y / N | |  | | | | |
| **Referrer Details (as applicable)** | | | | | | |
| Date of Referral: | |  | | | | |
| Referrer Name and profession | |  | | | | |
| Referrer GP Practice | | ` | | | | |
| Referring Hospital: | |  | | | | |
| Referring Ward Location: | |  | | | | |
| **Referrer Contact No:** | |  | | | | |
| Named Discharging Consultant: | |  | | | | |
| Date of Current Hospital Admission: | |  | | | | |
| Name of person handed over to on NHS@Home service | | Date/ Time | | | | |
| **Presenting Clinical history** | | | | | | |
| Date of onset  Do you think there is a suspected Sepsis (NEWS ≥5 or 3 in any parameter)?  Referral for a patient requiring high level support has been discussed and agreed with clinical specialist lead / Consultant: Yes  Consultant name: | | | | | | |
| **Treatment plan (please include clinical interventions required in the home environment- see pg 3 also** | | | | | | |
|  | | | | | | |
| Most recent observations | | BP       HR       SpO2       Temp       NEWS2  Date taken       Time taken | | | | |
| Please note any deranged baseline observations including any expected variation.  Medically reviewed and parameters set. | |  | | | | |
| Doccla box with Obs equipment given (if approp.) | | Yes / No  Obs kit no. | | | | |
| Patient information leaflet given. | | Yes | | | | |
| **Medication:** | | | | | | |
| Please prescribe any new medications or order TTAs required prior to referral to ensure no delay in treatment. Complete community administration chart if required | | | | | | |
| **Allergies:** | | | | | | |
| Name, reaction & Onset date | | | | | | |
| **ReSPECT** | | | | | | |
| ReSPECT form in place? | | Yes / No  Details: | | | | |
| Resuscitation Status | |  | | | | |
| Is the patient for escalation (back) to hospital in case of deterioration? | | Yes  / No | | | | |
|  | | | | | | |
| History of altered cognition/challenging behaviour pre-admission | | | | | Yes  / No  Details: | |
|  | | | | |  | |
| **Accommodation Access (tick as applicable)** | | | | | | |
| Patient can answer door | | | | Family or carer can answer door | | |
| Access via KeySafe  Number | | | | Access via Keycard | | |
| Access via staff on site | | | | Access other means | | |
| Any access issues? | |  | | | | |
| **Accessible Information Standards (tick as applicable)** | | | | | | |
| Patient does not identify as having complex communication needs | | | | Patient does identify as having complex communication needs | | |
| Comment on any requirements | |  | | | | |
| **Staff Safety** | | | | | | |
| Please detail any staff safety concerns. (patient / relative behaviour, pets, substance misuse etc) | | |  | | | |
| **Infection Prevention Control** | | | | | | |
| Detail any IPC issues | |  | | | | |
| **Covid-19** | | | | | | |
| Date the patient started having Covid-19 symptoms | |  | | | | |
| Covid test completed? | | Yes / No Date: | | | | |
|  | | | | | | |

**To be completed by the virtual ward triage**

|  |  |  |  |
| --- | --- | --- | --- |
| **Intervention required** | **Yes/ no** | **Frequency** | **Comments/specific details** |
| **Vital signs / NEWS 2 monitoring** |  |  |  |
| **Venepuncture**  Define blood tests required and date |  |  |  |
| **IV medication – Antibiotic therapy**  Has prescription and admin chart been issued? Where are meds being dispensed from? |  |  |  |
| **IV medication – diuretics/ other drugs**  Has prescription and admin chart been issued? Where are meds being dispensed from? |  |  |  |
| **IV medications – fluids**  Has prescription and admin chart been issued? Where are meds being dispensed from? |  |  |  |
| **Other medication management** |  |  |  |
| **Blood glucose monitoring** |  |  |  |
| **Nebuliser therapy -** Has nebuliser been issued? |  |  |  |
| **Weaning oxygen therapy -** Has oxygen been ordered? |  |  |  |
| **Urine analysis / sampling** |  |  |  |
| **Wound care** |  |  |  |
| **Fluid monitoring** |  |  |  |
| **ECG** |  |  |  |
| **Weight monitoring** |  |  |  |
| **Other (doc in comments)** |  |  |  |