**(GMSD) Greater Manchester Supported Discharge – Referral Form**

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| 1. **Referral Information**
 |
| **Name:**  | *Enter text here* | **D.O.B:**  | *Enter text here* | **NHS No.** | *Enter text here* |
| **Address:** | *Enter text here* | **Tel No:** | *Enter text here* |
| **First language:** | *Enter text here* | **Ethnicity:**  | *Enter text here* |
| **Any additional communication needs identified e.g. wears glasses? hearing aid?** | **Religion:**  | *Enter text here* |
| *Enter text here* | **Gender:** | *Enter text here* |
| **Does the person live alone?** | **Yes** [ ]  **No** [ ]  | **Pets?** | **Yes** [ ]  **No** [ ]  |
| **ACCESS TO PROPERTY:**E.g. person can answer the door, keys safe in situ, intercom, family member?Code | Any known concerns for a professional to enter your home?If yes, please state why: |
| *Enter text here* | *Enter text here* |
| **GP details:**  | *Enter text here* |
| **Name:** | *Enter text here* |
| **Address:**  | *Enter text here* |
| **Emergency contact details:**  | *Enter text here* |
| **Hospital :**  | *Enter text here* | **Ward:** | *Enter text here* | **Tel:** | *Enter text here* |
| **Professional completing referral/Job title:**  | *Enter text here* |
| **Date of admission:**  | *Enter text here* |
| **Reason for admission and brief medical history/diagnosis:**  | *Enter text here* |
| **Is there a DNaR in place?****Yes** [ ]  **No** [ ]  | **Signature:**  | *Enter text here* |
| **COVID Swab result:** [ ] **Date of swab or expected date:** *Enter date here* | **Positive** [ ] **Negative** [ ]  |

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| **Expected Pathway (please tick / add as appropriate)** |
| **Pathway 1** Support to recover at home; able to return home with support from health and/or social care. | [ ]  | ***Please describe which service / discipline is being requested (including therapy)*** *Enter text here* |
| **Pathway 2**Rehabilitation and enablement, of short term care in 24-hour bed setting | [ ]  | ***Please specify registration: Residential/Residential (Dementia) / Nursing / Nursing (Dementia) specialist placement / intermediate care*** *Enter text here* |
| **Pathway 3**Require ongoing 24-hour nursing care, often in a bedded setting with recovery and complex assessment.  | [ ]  | ***Please specify registration: Residential / Residential (Dementia) / Nursing / Nursing (Dementia) specialist placement*** *Enter text here* |
| **Pathway B – Fast Track (CHC)** |[ ]   |

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| 1. **Consent (referrals will not be accepted if this section is not complete)**
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| D2A process explained to the service user or their representative and consent gained for information sharing? | Yes [ ]  No [ ]  *Enter any additional text as required*. |
| Has a Mental Capacity Assessment taken place regarding the temporary care and accommodation destination decision in accordance with the Mental Capacity Act (2005)  | Yes [ ]  No [ ]  *Enter any additional text as required*. |
| Has this temporary offer of ongoing care and/or accommodation destination decision been reached in the person’s Best Interests in accordance with the Mental Capacity Act (2005)  | Yes [ ]  No [ ]  *Enter any additional text as required*. |

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| 1. **Are there any Safeguarding concerns/ risks identified?**
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| *Please ensure multi agency policy is adhered to, please summarise details of any concerns and actions taken* |
| *Enter text here* |

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| 1. **Clinical summary**
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| Has a District Nurse referral been made as well as D2A referralif so why? | Yes [ ]  No [ ] *Enter text here* |
| **Respiratory requirements:** |
| Does the service user have an aerosol generated procedure (AGP)? | Yes [ ]  No [ ]  |
| If yes, what is the procedure?  | *Enter text here* |
| How often, for how long and at what times (day or night) is the procedure initiated? | *Enter text here* |
| Can the service user initiate the procedure themselves? | Yes [ ]  No [ ]  |
| If no, how many staff are required to support service user in completing procedure? | *Enter text here* |
| **Toileting:** |
| Continent [ ]  | Incontinent: Urine [ ]  | Faeces [ ]   |
| Convene [ ]  | Pad/Pants [ ]  | Stoma [ ]  |
| Catheter**:** Short Term [ ]  Long Term [ ]   | Reason: *Enter text here*Date inserted: *Enter date here* |
| **Skin integrity/wound care:** |
| Waterlow/PURPOSE-T: | Yes [ ]  No [ ]  |
| Skin care wounds & grade (including site): | *Enter text here* |
| Equipment required (if applicable):  | *Enter text here* |
| **Nutritional requirements:** |
| Nil by mouth [ ]  | RIG [ ]   | PEG [ ]   |
| Self-caring [ ]   | Dentures [ ]   | No issues [ ]   |
| **Additional information:** (dietary preferences, altered consistencies, modified diet / fluids, assistance with eating and drinking, appetite, is there a SALT care plan in place)*Enter text here* |
| MUST: *Enter text here* | BMI: *Enter text here* | Weight: *Enter text here* |
| **Medicines management:** |
| Self-administer [ ]   | Family support [ ]   | District Nurse [ ]   |
| Carers [ ]   | Boxes & bottles [ ]   | Blister pack [ ]   |
| If so, please detail reason /application / frequency / risks. Please include any high-risk medicines and time specific medication? (Insulin/opiates/warfarin/anticoagulants/antiepileptic/Parkinson’s medications / antipsychotics/ controlled drugs?) |
| *Enter text here* |
| Does the person have any invasive devices, such as PICC lines, venflons etc. (specify device, size, and date of insertion)? |
| *Enter text here* |
| **Service user’s community pharmacy** (required for emergencies) |
| *Enter text here* |
| **Pain/symptom control:** |
| *Enter text here* |
| **Palliative discharge:** |
| Have anticipatory meds been prescribed? Is there an advance care plan in place? Is there an advance decision to refuse treatment in place? |
| *Enter text here* |
| **Concerns re: Mental Health or Behaviour:** |
| *Enter text here*  |

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| 1. **Function**
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| **Function** | **Current ability/support needs** |
| **a: Eating and Drinking***(Manage and maintain nutrition, swallow function) Include: SALT guidance/ Dietician recommendations. Dietary needs such Vegan/Halal.* | *Enter text here* |
| **b: Personal Care and Dressing***(Maintaining personal hygiene and appearance)* | *Enter text here* |
| **c: Toileting needs** *(Managing toilet needs)* | *Enter text here* |
| **d: Being Safe:** |
| **Mobility** *(equipment, distance, limitations)* | *Enter text here* |
| **History of falls** | *Enter text here* |
| **Transfers** *(bed, chair, toilet include any equipment required)* | *Enter text here* |
| **Stairs** *(stair lift, rails, ability)* **Environmental safety risks e.g. risk of fire/flood etc.** | *Enter text here* |
| **Equipment for Discharge (Please note which equipment is essential for discharge)**  |
| *Enter text here* |
| Date ordered:  | *Enter date here* | Delivery date: | *Enter text here* |

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| 1. **Expected Rapid Home Care Request (please consider natural support where appropriate)**
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| **Number of carers per visit:** | *Enter text here* |
| **AM:** duration of call, summary of needs and care delivery: | *Enter text here* |
| **Lunch:** duration of call, summary of needs and care delivery: | *Enter text here* |
| **Tea:** duration of call, summary of needs and care delivery: | *Enter text here* |
| **Bed:** duration of call, summary of needs and care delivery: | *Enter text here* |
| **Specific Nursing needs:** *(including detailed care plans re: Diabetes or COPD if appropriate)*  | *Enter text here* |

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