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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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** | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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)** |  |  |

|  |  |
| --- | --- |
| 1. **Consent (referrals will not be accepted if this section is not complete)** | |
| 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*. |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Clinical summary** | | | | |
| Has a District Nurse referral been made as well as D2A referral  if 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* | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Function** | | | | |
| **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* |

|  |  |
| --- | --- |
| 1. **Expected Rapid Home Care Request (please consider natural support where appropriate)** | |
| **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* |

GMSD F11 18/02/21