A close-up of a logo

Description automatically generated

Trafford Case Management

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Information**   * **Working Hours:** Monday to Friday, 8:00 AM – 4:00 PM * **Non-Urgent Service:** This service does not operate on weekends or bank holidays. * **Referral Cut-Off:** Referrals must be received by **2:00 PM on Fridays** to be processed before the weekend.   For **urgent referrals**, please contact the patient’s **GP, Out-of-Hours services, Trafford Crisis Response, NHS 111, or 999 in an emergency**.  We aim to triage referrals **within 24 hours**, excluding weekends and bank holidays. Please email referrals to **tspoa1@nhs.net** | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | |
| **Name** |  | **Emergency Contact** (family member, friend, neighbour, carer/s) | | | | | | |
| **Address** |  | **Name** | | | |  | | |
| **Home Telephone** |  | **Relationship** | | | |  | | |
| **Mobile Telephone** |  | **Contact Telephone** | | | |  | | |
| **Age** |  | **Main Language** | | | |  | | |
| **Date of Birth** |  | **Interpreter required?** | | | | **Yes** | | **No** |
| **NHS Number** |  | **Other communication needs? (Please state)** | | | | | | |
| **GP DETAILS** | |
| **Name** |  |
| **Address** |  |
| **Telephone** |  |
| **REFERRER DETAILS** | | | | | | | | |
| **Name** |  | | **Contact Number** | |  | | | |
| **Date of referral** |  | |
| **Has the patient consented to the referral?** | | | | **Yes** | | | **No** | |
| **Has the patient been made aware that social care and mental health records may be accessed as part of this referral?** | | | | **Yes** | | | **No** | |
| **Does the patient live alone?** | | | | **Yes** | | | **No** | |
| **Are there any safety issues?** | | | | **Yes** | | | **No** | |
| **Is the patient housebound?** | | | | **Yes** | | | **No** | |
| **Key Code** | | | |  | | | | |
| **Inclusion Criteria – please tick**  **2 or more long term conditions from the following:**   |  |  |  |  | | --- | --- | --- | --- | | Hypertension |  | Asthma |  | | Heart Failure |  | Diabetes |  | | COPD |  | Arthritis |  | | Other (specify) |  | | |   **Plus at least one of the following**   |  |  | | --- | --- | | 2 x Hospital admissions in last 12 months due to physical health |  | | 2 x or more A&E attendances in last 6 months due to physical health |  | | At risk of unplanned admission due to physical health |  | | Complex and problematic polypharmacy (10+ medications) |  | | Not in Immediate Crisis |  |  |  | | --- | | **Exclusion Criteria: Under 18, End of Life; Mental Health Crisis, Obstetrics, Pregnancy, Non-Trafford GP’s, Patients already admitted to a Nursing home.** |   **REASONS FOR REFERRAL:**  **Please give as much information and detail as possible for your referral. This will enable us to assess the patients and triage the referral please do not attach an EMIS summary.** | | | | | | | | |
| **Social history / Risk Factors** | | | | | | | | |



**Please complete all sections of the form. Any incomplete referrals may be returned to the referrer. Please send via email to** [**tspoa1@nhs.net**](mailto:tspoa1@nhs.net)