**Trafford Case Management Service Referral Form**

|  |
| --- |
| **PATIENT DETAILS** |
| **Name** |  | **Emergency Contact (family member, friend, neighbour, carer/s)** |
| **Address** |  | **Name** |  |
|  |  | **Tel. No** |  |
| **Home Telephone** |  | **Relationship** |  |
| **Mobile 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** |  |
| **Designation** |  |
| **Date of referral** |  |
| **Does the patient know they are being referred?** | **Yes** | **No** |
| **Does the patient live alone?** | **Yes** | **No** |
| **Are there any safety issues? (Please State)** | **Yes** | **No** |
| **Does the patient have capacity?** | **Yes** | **No** |
| **Is the patient a falls risk?** | **Yes** | **No** |
| **Key Code** |  |
| **Referral criteria:****Heart Failure****Chronic respiratory Conditions****Registered with a Trafford GP****New insulin dependent Diabetics (from District Nurses only)** |
| **REASONS FOR REFERRAL:****Please give as much information as possible explaining the patient’s needs. This will enable us to triage the referral. Please include relevant information / reports/ previous referrals.** |
| **Medications/Allergies**  |
| **Medical History / Chronic Conditions**  |
| **Social history / Risk Factors** |
| **Please complete all sections of the form. Any incomplete referrals may be returned to the referrer. Referrals can be made by any health professional. Please Email the referral to tspoa1@nhs.net.**  |
| **Exclusion Criteria** |
| **Under 18** | **In a nursing home** | **End of life** | **Mental Health Crisis** |
| **Pregnant** | **Outside Trafford area GP** | **Already under specialist nursing for referring condition** |  |

**For Case Management Team**

Triaged by

Date

**Referral Accepted?**

|  |  |
| --- | --- |
| Pathway Patient accepted on |  |
| Contact to be made within 3 working days. Initial visit to be carried out within 10 working days. |  |
| Which Team assigned to |  |

**Referral Declined?**

|  |  |
| --- | --- |
| Reason why declined |  |
| Referrer made aware |  |