**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 |  |