



Wandsworth Single Point of Access Referral Form

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| Referral Information | | |
| Date: | Time: | |
| Please choose the function you are referring to: | | |
| Complex Care Management, Daytime (including Community Nursing, Community Matron, Community Ward) | |  |
| Complex Care Management, Night (including Night/Twilight Nursing) | |  |
| Community Tissue Viability Specialist Nursing | |  |
| Community Diabetes Specialist Nursing | |  |
| Community Heart Failure Specialist Nursing | |  |
| Community Respiratory Specialist Nursing | |  |
| Community Continence Specialist Nursing | |  |
| Maximising Independence (including Primary Care Therapy Team, Rapid Response for mobility equipment and Intermediate Care services) | |  |
| Community Neurological Rehabilitation Team and early supported discharge for stroke | |  |
| Integrated Falls Team | |  |
| EOLC Community Nursing Service | |  |
| Facilitated and Supportive Discharge Services (previously Settling Home Service) | |  |
| Brysson Whyte Rehabilitation Unit | |  |

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| Patient Information | | | | | |
| Patient’s Full Name: | |  | | Patient’s Address: |  |
| DOB: |  | Gender: |  | Postcode: |  |
| NHS Number: | |  | | Contact Number: |  |
| Ethnicity: | |  | | Alternative Number: |  |
| GP Practice: | |  | | GP Telephone Number: |  |
| GP Address: | | | |  | |
| Next of Kin / Carer/ Social Worker |  |
| Does the patient live alone? | | | | Contact Number: |  |
| Is the patient able to answer the door? | | | | Patient aware of referral? | |
| If no, how can access be gained? | | | | If no, reason: | |
| Are they house/bed bound? | | | |
| Preferred Language: | | | | Is an Interpreter required? | |
| Current location of patient if not home: | | | | | |

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| Referrer’s Details | |
| Full Name: | Telephone Number: |
| Role: | Fax: |
| Designation: | Email (nhs.net) |
| Base/Hospital: |

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| Referral Information | | |
| Reason for referral: | | Urgency:  Urgent (visit within 4 hours) Initial contact with patient made within 1 hour of receipt of referral  Less Urgent (visit within 24 hours) Initial contact with patient within 4 hours of receipt of referral  Routine (visit within 72 hours) Initial contact with patient within 6 hours of receipt of referral |
| Current Diagnosis/Presentation/Treatment/Relevant Investigations: | | |
| Past Medical History: |  | |
| Current Medication: | | |
| Allergies: | | |
| Has the patient had a fall in the last year? | |  |
| Essential Investigations Required:  Heart Failure:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Presenting symptoms | Yes | No | | Please give details | | | Echocardiogram attached ((DO NOT refer without echo) |  |  | |  | | | ECG Attached |  |  | |  | | | Latest bloods |  |  | |  | | | U&E |  |  | |  | | | NT – proBNP |  |  | |  | | | FBC |  |  | |  | | | TFT |  |  | |  | | | LFT |  |  | |  | | | Fasting lipid profile |  |  | |  | | | Physical Assessment: |  |  | |  | | | JVP Measurement if known |  |  |  | |  | | | Extent of dependent oedema |  |  |  | |  | | | Chest auscultation |  |  |  | |  | | | Weight |  |  |  | |  | | | BP |  |  |  | |  | | | Heart Rate |  |  |  | |  | | |  |  |  |  | |  | | | | |
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| Diabetes Specialist Nurses Only:   |  |  |  |  | | --- | --- | --- | --- | | Presenting symptoms | Yes | No | Please give details | | Patient has become poorly controlled |  |  |  | | Newly diagnosed but housebound |  |  |  | | Insulin start |  |  |  | | Review of treatment regimen |  |  |  | |  |  |  |  | | | |
| Continence Specialist Nursing:   |  |  |  |  | | --- | --- | --- | --- | | Presenting symptoms | Yes | No | Please give details | | Urinary Urgency |  |  |  | | Urinary Frequency |  |  |  | | Nocturia |  |  |  | | Urge Incontinence |  |  |  | | Stress Incontinence |  |  |  | | Faecal Symptoms |  |  |  | | Constipation |  |  |  | | Voiding Difficulty |  |  |  | | Pelvic Organ Prolapse |  |  |  | | Men only - Post Prostectomy |  |  |  | | Does patient wear pads? If so how many do they use daily and what type? |  |  |  | | Other Essential Information | | | | | Urinalysis/MSU (within last month) |  |  | Date:  Result: | | Has this patient previously received assessment/ treatment for this problem before? |  |  |  | |  |  |  |  | | | |
| Tissue Viability Service:   |  |  |  |  | | --- | --- | --- | --- | | Type of Wound | Location | Dressing Type | Brief Description | | Leg Ulcer |  |  | ABPI: | | Pressure Ulcer |  |  |  | | Other Wound |  |  |  | |  |  |  |  | | | |
| Respiratory Specialist Nurses:   |  |  |  | | --- | --- | --- | | Reason for Referral | Yes | No | | Worsening of a previously stable condition |  |  | | Acute exacerbation |  |  | | Recent hospital admission for COPD and needs follow up |  |  | | Housebound and unable to attend clinic or surgery |  |  | | Needs confirmation of diagnosis |  |  | | O2 assessment |  |  | | Other (please specify) |  |  | |  |  |  | | | |
| Any other relevant details? | | |

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| Social Communications | |
| Best Method of Contact: | Telephone via patient: Telephone via carer: Post: Other: |
| Any potential risk factors? | |

Completed forms should be sent to

[wandsworth.spoc1@nhs.net](mailto:wandsworth.spoc1@nhs.net)

*If you have any queries regarding the referral or to make a referral over the telephone, you can contact the Wandsworth SPOC on 0300 1237763. This number can also be given to patients.*