



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 referralLess 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:

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| 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:

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| Presenting symptoms | Yes  | No  | Please give details |
| Patient has become poorly controlled |  |  |  |
| Newly diagnosed but housebound  |  |  |  |
| Insulin start |  |  |  |
| Review of treatment regimen |  |  |  |
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| Continence Specialist Nursing:

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| 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? |  |  |  |
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| Tissue Viability Service:

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| Type of Wound | Location | Dressing Type | Brief Description |
| Leg Ulcer |  |  | ABPI: |
| Pressure Ulcer |  |  |  |
| Other Wound |  |  |  |
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| Respiratory Specialist Nurses:

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| 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) |  |  |
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| 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

*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.*