**Wandsworth CAHS Secondary Care Referral Form v0.5**

|  |
| --- |
| **Patient details:** |
| Title:       | First name(s):        | Last name:       |
| Gender:       | NHS number:       | D.O.B:        |
| Ethnicity:        |
| Address:        |
| Mobile telephone number:       Landline telephone number:        | Email address:        |

Alternative contact / Next of kin name & number:

|  |  |
| --- | --- |
| Has the patient consented to this referral?If No, please confirm why not:       |  [ ]  Yes [ ]  No  |
| Has the patient consented to the CAHS clinicians accessing Primary Care EMIS to support this referral? |  [ ]  Yes [ ]  No  |
| Main language:        Is an interpreter required? |  [ ]  Yes [ ]  No  |
| Does the patient have a significant learning disability? List details:       |  [ ]  Yes [ ]  No  |
| Any issues that our staff need to be aware of re their personal safety?If yes, list details:       |  [ ]  Yes [ ]  No  |
| Does the patient have any sensory impairment?If yes, please provide details:       |  [ ]  Yes [ ]  No  |
| Is the patient able to attend clinic?  |  [ ]  Yes [ ]  No  |
| Do you undertake house calls to this patient?  |  [ ]  Yes [ ]  No  |
| Is the patient able to answer the door?  |  [ ]  Yes [ ]  No  |
| If not able to answer the door, then please provide access details:         |
| **I would like this patient to be seen by:** |
| **[ ]** Community Nursing crisis (24/7) | (4 hrs) | (U) | [ ]  Community Ward urgent | (1 day) | (U) |
| **[ ]** Community Nursing urgent (24/7) | (24 hrs) | (S) | [ ]  Community Ward routine | (5 days) | (R) |
| **[ ]** Community Nursing routine (24/7) | (72 hrs) | (R) |  |  |  |
| [ ]  Diabetes Team urgent | (2 days) | (U) | [ ]  Heart failure team priority 1 | (1 day) | (U) |
| [ ]  Diabetes Team routine | (10 days) | (R) | [ ]  Heart failure team priority 2 | (5 days) | (S) |
| DESMOND (refer via diabetes book & learn)  |  |  | [ ]  Heart failure team priority 3 | (10 days) | (R) |
| [ ]  Facilitated & Supported Discharge |  |  | **[ ]** Continence team  | (10 days) | (R) |
| **[ ]** Maximising Independence urgent (72 hours) (U) | [ ]  Phlebotomy (provide requirements below) |
| [ ]  Maximising Independence routine (3 weeks) (R) | Quick Start Team (Use separate form) |
| [ ]  Respiratory team urgent  | (4 hrs) | (U) | [ ]  Tissue viability team urgent | (2 days) | (U) |
| [ ]  Respiratory team routine | (5 days) | (R) | [ ]  Tissue viability team routine | (5 days) | (R) |

|  |
| --- |
| **Reason for referral / current problem / areas to be addressed / goals:** **(please detail what you would like our services to address)**                      |
| **To ensure clinical safety, you may be contacted for further information.****Please attach relevant supporting documentation:****[ ]**  Relevant consultant / therapy discharge reports**[ ]** PRN authorisation**[ ]** Syringe pump documentation **[ ]** Imaging reports **[ ]** Relevant blood results **[ ]** FormalEchocardiogram report (for all heart failure referrals) |
| **Referrer Details** |
| Date of referral:            | Referrer / Person Registering referral:           Referring Org:             |
| Contact number:      | Fax number:       |
| Referrer availability for call back:       |
| Address:            |
| NHS.net email address:       | GP practice:       |
| **Please return this referral form to the Wandsworth Single Point of Access (SPA) via email to** **clcht.wandsworthspa@nhs.net** **. If the referral is urgent or clinically high risk, then you are advised to call us on 0333 300 2350 to check that it has been received.**  |