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

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| **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:

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| 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) |

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| **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**](mailto: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.** | |