|  |  |  |  |
| --- | --- | --- | --- |
| **Surname:** |  | **Hospital number:** |       |
| **Forename:** |  | **NHS number:** |       |
| **Preferred Name:** |  | **Acute centre:** |       |
| **Date of birth** (ddmmyy)**:** |  | **Ward:** |       |
| **Address:** |  |  |  |
| **Postcode:** |  | **Contact telephone number:** |       |
| **Telephone:** |  | **HIV consultant:** |       |
| **Gender**  | Male / female / transgender |  |  |
| Next of kin: |       | Relationship: |       |
| Contact telephone number: |       | Aware of HIV diagnosis: | YES / NO |
| **Ethnicity** (please tick one from the list below): |  |  |
| White British | Asian/Asian British – Other | Mixed White/Black – Asian |
| White Irish | Black/Black British – Caribbean | Mixed Whtie/Black – other |
| White Other | Black/Black British - African | Chinese |
| Asian/Asian British – Indian | Black/Black British - Other | Other Ethnic Group |
| Asian/Asian British – Pakistani | Mixed White/Black – Caribbean | Not Stated |
| Asian/Asian British – Bangladeshi | Mixed White/Black – African | Unknown |
| **Sexual orientation** (please pick one): | **Religion/spirituality:**  |
| Heterosexual / Gay / Lesbian / Bisexual /  | **First language:**  |
| Not stated / Unknown | **Interpreter Required?** YES / NO |
| **GP details:** | **External Social worker details:** |
| GP name:       | Name:       |
| Practice address:       | Telephone number:       |
|       | Borough:       |
| Postcode:       | Is the patient currently in receipt of benefits? |
| Telephone number:       | YES / NO / No recourse to public funds (if yes, please specify below: |
| GP practice code:       |  |
| Does the patient have contact with a GP? YES / NO | If the patient has no allocated external social worker, is a referral required? YES / NO |
| **Housing situation:** | **Commissioning/funding details:** |
| Lives alone? YES / NO (if no, please specify with whom): | Clinical Nurse Specialist:       |
|  | Contact telephone number:       |
| In permanent or temporary accommodation? | Commissioner:       |
| PERMANENT / TEMPORARY | Contact telephone number:       |
| * Local authority
* Housing Association
* Owner occupier
* Private landlord
* Hostel
* No fixed abode
 | Funding Agreed: YES / NO / PENDING(Please note that a bed cannot be offered without approved funding) |
| **Reason for referral:** | **Expected outcomes:** |
| * 1-2 weeks respite admission\*
* 4-week assessment admission+
* 4–6-week assessment admission+
* 4–8-week assessment admission+
* 12-week assessment admission+

\*does not include therapist interventions, but medical care from doctors and nurses only+includes full access to all relevant therapists and medical care from doctors and nurses |       |
| **Summary of assessment/admission requirements**(Please tick all that apply)**:** | **Behavioural Risk Factors** (please tick all that apply): |
| * Physical Impairment
* Cognitive Impairment
* Adherence Support
* Psychological Support
* Palliative Care
* Non-Palliative Symptom Control
 | * Agitation
* Wandering
* Self-harm
* Verbal Aggression
* Physical Aggression
* Sexual Disinhibition
* Drug/Alcohol Misuse
* One-to-One Specialling
 |
| **Mobility** (please tick): | **Domestic Routines** (please tick): |
| * Independent
* Assistance from 1
* Assistance from 2
* Hoist
* Bedbound
 | * Independent
* Support from another
* Not known
 |
|  | **Personal Care** (e.g., washing/dressing): |
| Risk of falls? YES / NOHistory of falls? YES / NOCurrent equipment Being Used (if applicable):      | * Independent
* Unmotivated but physically able
* Assistance of 1
* Assistance of 2
* Dependent for all care needs

Are pressure areas intact? Yes No |
| **Current team input** | **Yes** | **No** | **Name** | **Contact telephone no.** |
| Physiotherapy |       |       |       |       |
| Occupational Therapy |       |       |       |       |
| Speech & Language Therapy |       |       |       |       |
| Dietitian |       |       |       |       |
| Social Worker |       |       |       |       |
| Psychiatry |       |       |       |       |
| Psychology |       |       |       |       |
| Chaplain |       |       |       |       |

|  |  |
| --- | --- |
| **Communication/Swallowing** (please tick those that apply): | **Continence** (please **tick those that** apply): |
| * Dysarthria
* Dysphasia Expressive Receptive
* Dysphagia
 | * Urinary Incontinence
* Catheter
* Conveen
* Faecal Incontinence
 |
| **Cognition** (please tick) | **Adherence** (please tick) |
| * Insight to present condition
* Orientated to date/time/place
* Confused
* Memory Deficits
* Any other Cognitive Impairment
 | * Non-adherent
* Takes medications under direct observation
* Requesting medications from staff
* Self-medicating from dossett finger
* Self-medicating from dossett box
 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Dietary needs** (please tick): | Normal diet | Soft diet | Puree | Nil by mouth | NG/PEG feed |
| Does the patient require nutritional supplements? | NO | YES (if yes, please specify which)       |
| Any other dietary requirements/known food allergies?      |

**Please note that referral will NOT be processed unless all fields are completed**

**Name of person completing form:**

**Designation:**

**Date:**

**MEDICAL REFERRAL FORM Private and Confidential**

|  |  |
| --- | --- |
| Patient name:       | Date of referral:       |
| Date of birth (ddmmyyyy):       |  |
| HIV consultant:       | Consultant email:       |
| Acute Centre:       | Contact telephone no.       |
| Date of HIV diagnosis:       | Recent CD4 | Date:       |
|  | Nadir CD4 | Date:       |
| Stage of HIV: | A | B | C | Recent VL | Date:       |
| Recent Issues including HIV-related illnesses, admissions and management. psychiatric, drug and alcohol etc:      |
| Other past medical history including. HIV-related, psychiatric, medical, drug and alcohol issues etc:      |
| Current ARV’s (please include date started):       | Other current medications:      |
| Allergies:       |  |
| Recent investigation results (including brain imaging):      |
| Resuscitation Status:Date of DNR decision:What discussions have taken place regarding patient’s prognosis? |
| Have you included a recent discharge summary/clinic letter? | YES | N/A |
| Have you included relevant investigation reports/blood results? | YES | N/A |

Please attach any relevant additional information such as blood results, relevant investigation reports and reports from other specialties including psychiatry, neurology etc

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Referring Doctor:**  |  | **Signature:** |  |
| **Position:** |  | **Date:**  |  |
| **Contact Number/Bleep:** |  | **Ward/clinic:** |  |