|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 / NO  History of falls? YES / NO  Current 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:** |  |