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| **Community Services Single Point of Contact Referral Form** |
| **Personal Details** |
| NHS Number:  | Date of birth:  |
| Title:  | First Name:  |
| Surname:  | Known as:  |
| Address:   |
| Post Code:  | Telephone:  |
| GP (if not referrer):  | Surgery:  |
| Nationality/Language:  | Ethnic Origin:  |
| Gender:  | Religion:  |
| **Next of Kin** |
| Name: i | Relationship: |
| Address:  |
| Post Code:  | Telephone:  |
| Does the patient have a keysafe/are there any access issues at the patient’s residence?Please provide the contact details of a person who can confirm the keysafe number.**Please DO NOT write the keysafe number on this form** |
| When all sections are completed, please forward using electronic referral via SystmOne oremail to hnf-tr.csspoc@nhs.net |
| **Referrer Information** |
| Referrer name: | Occupation: |
| Organisation: Date: <Today's date> | Telephone: |
| **Intervention required** |
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| [ ]  | Cardiac Rehab | [ ]  | Heart Failure | [ ]  | Respiratory Nursing |
| [ ]  | Urgent Community Response (Crisis) | [ ]  | Home Oxygen(see HOS-AR form) | [ ]  | Respiratory Physiotherapy |
| [ ]  | Continence Service | [ ]  | MSK Physio Outpatients | [ ]  | Speech and Language Therapy  |
| [ ]  | Diabetes | [ ]  | Occupational Therapy | [ ]  | Stroke Services  |
| [ ]  | Dietetics | [ ]  | Physiotherapy - Community | [ ]  | Tissue Viability  |
| [ ]  | District Nursing | [ ]  | Pulmonary Rehabilitation | [ ]  | Intermediate Care |
| [ ]  | Pharmacy | [ ]  | COVID-19 Swab Testing | [ ]  | Elderly Medicine |
| [ ]  | Virtual Ward - **Please ensure the patient meets the criteria for Virtual Ward.**  **When selecting Virtual Ward no other service should be selected.** |

Is this referral [ ] Urgent [ ] Routine  |
| Is a Frailty Assessment required? Yes / No. If yes:EFI Score:Rockwood Score:Clinical need: *(Could include: holistic assessment, incorporating; nutritional status, anticipatory or advance care planning, multifactorial falls assessment, complex or challenging symptom control –* ***medication reviews would be completed if identified in the holistic assessment****)*: |
| Reason for referral (include relevant previous medical history): |
| Can this patient be seen in a clinic? [ ] Yes /[ ]  No  |
| Has the patient consented to this referral? [ ]  Yes [ ]  No   |
| Other relevant clinical / patient information (**including lone worker safety considerations**): |

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| **Home Oxygen Service Assessment and Review (HOS-AR) Referral Form Scarborough, Ryedale and Whitby****(Please also see referral pathway for guidance)** |
| **MEDICAL HISTORY** |
| Diagnosis: |  |
| Resting SpO2 on Air: |  | Last exacerbation date: |  |
| Spirometry (date):  | FEV¹ | FEV¹ % | FVC |
| Completed and reviewed within 3 months of referral: | CXR [ ]  | ECG / ECHO [ ]  | FBC [ ]  |
| Is patient fully optimised? | Yes / No |
| **OXYGEN REQUESTED (please select)** |
| [ ]  Long Term Oxygen Therapy * Resting SpO2 ≤ 92% on 2 occasions or
* ≤ 94% Polycythaemia/Pulmonary HTN
 | [ ]  Ambulatory Oxygen Therapy * Evidence of exercise desaturation

( SpO2 <90% *or* SpO2 drop >4% )* Require oxygen outside of the home
 | [ ]  Palliative Oxygen Therapy * Symptomatic patient with SpO2 92%<
 |
| Exclusion Criteria:* Current smokers *(Please refer to smoking cessation, reconsideration for oxygen when 3/12 smoke free)*
* Patients condition not fully optimised *(please consider appropriate referral to Pulmonary Rehabilitation)*
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| **COMMUNITY DIABETES REFERRAL FOR** **SCARBOROUGH AND RYEDALE****(Please also see referral pathway for guidance)****ALL PATIENTS NEED TO BE CONSIDERED FOR GROUP EDUCATION PRIOR TO REFERRAL FOR ONE:ONE SPECIALIST CARE** |
| **MEDICAL HISTORY** |
| Diagnosis: | Type 1 Diabetes [ ]  Type 2 Diabetes [ ]  Secondary disease [ ]  Details ( EG. Pancreatitis) |
| Medications  | Oral Meds  | Insulin  | Other meds |
|  |  |  |  |
|  |  |  |  |
| Relevant history  | Alcohol Abuse  | Drug Abuse | Is patient fully optimised in oral medication pathway?[ ]  Yes [ ]  Contraindicated |
|  |
| [ ]  Blood tests HBa1cU&EsLFTSCholesterolRenal concerns E.g. AKI or high stage of CKD | [ ]  Libre Flash Glucose Monitoring (Community Criteria)Has routinely required eight or more blood glucose tests per day as recommended by the Specialist Diabetes Team🞏 Has routinely required eight or more blood glucose tests per day as recommended by the Specialist Diabetes Team🞏 Unable to routinely self-monitor blood glucose due to disability and requires carers to support glucose monitoring and insulin management.🞏 Occupational or psychosocial circumstances that warrant a six month trial of FreeStyle Libre.🞏 Recurrent severe hypoglycaemia or impaired awareness where a trial of FreeStyle Libre® is more appropriate for the individual’s specific situation.🞏 Two or more admissions with diabetic ketoacidosis in the last 12 months.🞏 Has diabetes associated with cystic fibrosis and is on insulin therapy.  | EDUCATION STRUCTURED  TYPE 1- DAFNE [ ]  TYPE2- STRUCTURED EDUCATION [ ]  (Need up to date HBa1c and Cholesterol) |
| Exclusion Criteria:Pregnant patients, insulin pump patients, Renal dialysis patient. (If in doubt check the criteria pathway) or speak with the DSN TEAM Via CAS. |