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| [Home - Virgin Care](https://www.google.co.uk/url?sa=i&url=https://virgincare.co.uk/&psig=AOvVaw1x9szZQzTC0B6J1UtmU_Nr&ust=1585732817266000&source=images&cd=vfe&ved=0CAIQjRxqFwoTCLi_sZyxxOgCFQAAAAAdAAAAABAE)**HOSPITAL DISCHARGE TO ASSESS FORM**  **including Home First , Social Care and Intermediate Care**  **Hospital discharge for medically stable patients who need ongoing clinical or personal support on discharge** | | |
| **1. Patient’s name:** | **EXPECTED CARE NEED**  **Home  Bed Based** | |
| **2. Patient’s NHS #:** | **7. NOK’s Name and Telephone Number(s)** | |
| **4. Patient’s DOB:** | **8. Referrer’s name and contact details:** | |
| **5. Patient’s address:**    **Postcode:**    **Tel (home):**  **Tel (mobile)**: | **9. TEP and DNAR:**  **Yes  No**  **Date**: | |
| **10. Has the patient been advised of this referral?**  **Yes  No**  **Is the patient objecting? Yes  No**  **Does the patient have capacity? (informal assessment)**  **Yes  No**  **If they do not have capacity have the family been informed? Yes  No** | |
| **GP Surgery:** |
| **11. Date/time of referral:** | |
| **SOURCE OF REFERRAL (i.e. who is referring?)** | | |
| **Date of Admission:**  **Expected Date of Discharge:** | | **Hospital and Ward:**  **Reason for admission to hospital:** |
| **LEVEL OF CARE NEEDS IN LAST 24 HRS** | | |
| **Mobility** (assistance required, aid)  **Transfers** (toilet/bed/chair)  **ADLS** (meal prep, PC)  **Cognition** (normal, severely impaired etc)  **Medication** (list and administration needed etc)  **Pressure Areas** (location, grade, equipment)  **Continence**  **Equipment requirements (including bariatric )?** | | |
| **GENERAL HEALTH** | | |
| **Past Medical History:** | **Mental Health / Dementia History:** | |
| **Is this patient medically stable? Yes  No**  (Have they recently been seen by a medical professional)  Yes  No    **COVID19 status on referral date?**    **Positive  Negative** | **Palliative?**   **Yes  No**  **Comments(**Palliative team involved, DN, end stage?, rehab potential, pain and symptom management) | |
| **Communication difficulties?**   **Yes  No**  (Speech, visual, hearing, language) | | |
| **SOCIAL HISTORY AND NEW SUPPORT NEEDS** | | |
| **What is the current social situation**  (lives alone, warden, family involvement etc) | **New support needs**  (package of care, private care, care provided by family/friend/neighbour, meals on wheels, day centre etc)    **Likely level of care required?**    **If home, will heating be on ? access to food ?** | |
| **Housing Type**  (Ground floor, stairs to flat/house, bungalow, house with internal stairs etc.) |
| **Access to property/Key safe patient to give access** |
| **Other agencies involved**  (Social services, DN, podiatry, falls clinic, Palliative team, voluntary):  **Existing POC? Yes  No** | | |
| **Are you aware of any safeguarding issues?**  **Yes  No** | **Are there any identified risks for a home visit?**  (pets, family, environment, mental health, criminal Hx, location of property, substance abuse etc) | |