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| Home - Virgin Care**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)  |