|  |
| --- |
| **Before proceeding, please tick to indicate you**  **have explained the statement below to the patient/client**  **Date ……………………………………**  The information you give on this form will be used for the purposes of providing you with support through Derbyshire Home From Hospital Support Service. By providing the information, you agree that it can be held on your behalf. It will be held on a computer system run by SDCVS in accordance with the Data Protection Act. Your information will not be shared with other agencies without your consent except in circumstances where you are at immediate risk. |

**Referrer Details**

Are you referring yourself?

Are you referring a family member or friend?

Are you a professional worker referring a patient/client?

**Please complete all relevant details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | | |
| Last Name |  | | |
| Organisation |  | | |
| Team |  | Role |  |
| Phone Number |  | Email |  |

**Patient/Client Details**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | First Name |  | | | Surname |  | |
| Date of birth | |  | | Age |  | NHS Number |  | |
| Address including Postcode | |  | | | | | | |
| Email address | |  | | | | Key Safe?  Yes  No  Key Safe Number: | | Careline fitted?  Yes  No |
| Gender | | Male  Female | | | | Phone Number | |  |
| Ethnicity | |  | | | | Lives alone? | | Yes  No |

**Primary Reason for referral**

|  |  |
| --- | --- |
| **Why are you referring this patient/client?** | |
| To support a planned hospital discharge – Please note which hospital and ward. |  |
| To aid recovery following a recent hospital discharge  (within 5 days) and improve chance of recovery at home |  |
| To help prevent a hospital admission |  |
| To reduce the level of support needed from NHS/Adult Care |  |
| To promote mental/emotional health and wellbeing |  |

**GP Details**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Surgery |  | Address |  |
| Name of GP |  | Phone Number |  |

**Next of Kin**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone Number |  |
| Relationship to patient/client |  |

**Person to contact if different from patient/client**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone Number |  |
| Relationship to patient/client |  |

**Primary Medical Condition**

What is the main medical condition that necessitates this referral?

|  |  |  |
| --- | --- | --- |
| Dementia | Heart Condition | Respiratory Condition |
| Stroke | Fall | Mental Health Need |
| Other (please state) |  | |

**Additional Medical Information**

Please give as much information as you can about any additional medical/health issues that the patient/client has? It is particular important to tell us about any dementia issues, Sensory loss, Learning Disability and other long-term conditions.

|  |
| --- |
|  |

**Home Circumstances and Support**

|  |
| --- |
| Derbyshire Home from Hospital Service provides short term low level practical support such as help with shopping, collecting medication, support for up to a maximum of six weeks. Please give us as much information as possible about why you feel the patient/client would benefit from this service. What are the patient/client's circumstances and needs including support through family or friends? |

**Additional Information**

|  |
| --- |
| Does the patient/client have a Derbyshire County Council Adult Care Package in place? If so please give details of relevant Social Care Team including contact details. |

|  |
| --- |
| Have you made referrals to any other agencies/organisations with regard to this patient/client? If so, please give details including contact details. |

|  |
| --- |
| Do you know of any other agencies/organisations which are already involved with this patient/client? If so, please give details. |

**Risk Assessment**

Derbyshire Home from Hospital Support Service is delivered by a combination of staff and volunteers who may be visiting the client alone. They will not always be able to do ‘double up’ visits so it is very important that you provide as full a picture as possible of any issues that the client or their property may present which might put people at potential risk. Please answer the questions below as fully and frankly as possible.

**Before moving on to the main risk assessment questions please also answer the Covid 19 Risk Assessments Questions:**

|  |  |  |
| --- | --- | --- |
| Has patient tested positive for Covid 19 in the last 7 days. | Yes / No | What was the date of the test? |
| Does the patient or anyone in their household have Covid 19 Symptoms? | Yes/ No | If yes please provide details here: |

|  |  |
| --- | --- |
| Has patient received all upto date Covid 19 vaccination offered? | Yes / No |

**Please continue below to answer further risk assessment questions. Thank you**

|  |  |
| --- | --- |
| Is there any risk to lone workers/volunteers visiting the client such as inappropriate or aggressive behaviour or potential violence? |  |
| Is the client a risk to themselves? |  |
| Are you aware of any past safeguarding issues including any incidences of domestic abuse? |  |
| Does the client have a mental health condition which may cause a risk to themselves or others? |  |
| Does the client have dementia? |  |
| Does the client have a history of substance or alcohol misuse? |  |
| Does the client, or other member of the household, smoke? |  |
| Are there any other risk factors or hazards that lone workers/volunteers should be aware of when visiting the client? |  |

**Please return this form to secure email:** [**home@dhfh.org.uk**](mailto:home@dhfh.org.uk) **or please call 01283 817417**