**CSH Single Point of Access (SPA) Community Services Referral Form**

*\*Mandatory field must be completed for referral acceptance*

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| **\*Community Services - Please tick the services required** | | | |
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| **Community Nursing Team**  *Community Neighbourhood Team.*  *Housebound service includes wound care, palliative care needs, catheter care, bowel care, leg ulcers.* *PICC line flushes and removal of chemotherapy.* |  | **Locality Hubs**  *Community Neighbourhood Team.*  *An integrated physical health, mental health, and care service for older people with frailty.*  *Ashford, Bedser and Thames Medical Hubs*  *Explicit Consent Required* |  |
| **Insulin Administration Team**  *Community Neighbourhood Team.*  *All patients must have a minimum 2 week’s supply of pre-filled insulin pens and needles plus a sharps box at their residence.* |  | **Medicines Optimisation in Care Homes (MOCH) Service:**  *Specialist pharmacy service providing medicines reconciliation and medicines optimisation for care home residents.*  *Explicit Consent Required* |  |
| **Complex Wound Clinics**  *Community Neighbourhood Team. Non-housebound patients requiring complex wound care, leg ulcer care and negative pressure dressings. Operational Mon-Fri 9am-5pm.* |  | **Podiatry (Adults over 18s)**  *Community Neighbourhood Team.*  *Musculoskeletal assessment; High risk foot / wound care (foot ulcers); nail surgery (in-growing toenails); routine assessment; domiciliary visits.* |  |
| **Continence** *Community Neighbourhood Team.*  *Continence / catheter specialist nursing service. Catheter clinics for independently mobile patients and telephone continence clinics.* |  | **Podiatry (Children’s)**  *Musculoskeletal assessment; nail surgery (in growing toenails), assessment* |  |
| **Community Rehabilitation Team (CRT)**  *Community Neighbourhood Team.*  *A specialist general and neuro-domiciliary physiotherapy and occupational therapy service. A neuro-outpatient service is also available.*  *All referrals must demonstrate rehab potential.* |  | **Respiratory**  *General respiratory assessment, respiratory physiotherapy assessment, respiratory occupational therapy assessment, ambulatory oxygen assessment. (Long Term Oxygen Therapy ‘LTOT’ is not provided by the Community Respiratory Team)* |  |
| **Diabetes Specialist Nurses**  *Community Neighbourhood Team.*  *Diabetes specialist nurses* |  | **Respiratory Rehabilitation**  *Pulmonary rehabilitation* |  |
| **Dietetics** *Community Neighbourhood Team.*  *Service for domiciliary visits, care home and community hospital inpatient dietetics provided at Woking Hospital.* |  | **Speech and Language Therapy (SLT)**  *Community Neighbourhood Team. Outpatient and domiciliary service including care homes.* |  |
| **Heart Failure**  *Community Neighbourhood Team.*  *Specialist nursing service for heart failure* |  | **Tissue Viability Team (TVN)**  *Community Neighbourhood Team.*  *Specialist advisory service for wound management* |  |
| **Phlebotomy** *Community Neighbourhood Team.*  *Blood tests for housebound patients within 48 hours, two weeks or one month. Where possible please ensure Phlebotomy requests include an electronic request form.* |  | **Integrated Neighbourhood Multidisciplinary Team (MDT)**  *Community Neighbourhoods Teams.*  *Explicit consent is required for any MDT.* |  |

**Please complete the reason for referral and the correlating sections on page 3, 4 & 5 for each selected service where applicable.**

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| **\*Personal Details** |  |
| Surname: | Mr Mrs Miss |
| Forename: | Date of Birth: |
| Address | NHS No: |
| Home Telephone Number:  Email address: Consent to use: Yes / No | Mobile: |
| Does the patient have any communications needs for spoken communication? | YES/NO (if Yes please detail) |
| Does the patient have any communication needs for written communication? | YES/NO (if Yes please detail) |
| GP Name, Address & Telephone Number: | |
| Is the patient able to attend an outpatient appointment? | YES/NO |
| Next of Kin /Carer’s details | Name:  Contact details: |
| Do we need to contact you regarding access or Key Safe details? | YES/NO |

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| **\*Referrer Details:** | |
| Referrer’s Name & Organisation: |  |
| Referrer’s telephone number: |  |
| Referrer’s email address: |  |
| Date of referral: |  |

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| **\*Consent:** |
| Has consent been obtained for this referral? YES / NO  Please detail third party consent if applicable: |

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| **\*Explicit Consent:** |
| The patient has received an explanation of the service and the range of health, mental health, social care and voluntary sector organisations that are involved. This has included an explanation that the patient’s full GP record will be made available to staff operating within the community neighbourhood services and that information will be shared between providers and with other relevant health, mental health and social care services. The patient has had the opportunity to view supporting information if they wish (e.g. Hub leaflet, MOCH leaflet, Neighbourhood leaflet or online materials), to ask any questions they may have and have received satisfactory responses. The patient is happy that the consent they are providing is freely given, specific and informed in relation to the referral and associated information sharing.   |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | Explicit patient consent has been gained for this referral and information sharing |  |  | | **If no;** | | | | The referral is being made in the patient’s best interests following an assessment of capacity in line with the Mental Capacity Act 2005. |  |  |   For the latest information and how patient information is used and shared within the Locality Hubs, MOCH and other Community Neighbourhood Services please visit our website: [www.cshsurrey.co.uk](http://www.cshsurrey.co.uk/) |

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| **Alerts:** |
| Are there any alerts relating to this patient: |

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| **\*Reason for Referral:** |
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| **Urgent:** YES / NO (If YES, please detail why) |

**\*Please include an up-to-date EMIS or Discharge Summary that includes any past medical history, medication and diagnostic information.**

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| **\*Service referred to: \***  *Please ensure you complete the required information in the fields below for the service you are referring to.* |
| **Community Nursing Team:** |
| **Insulin Administration Team:**  Name of insulin(s), dose(s) and time(s) of day to be administered:  Date and time for visits to begin for insulin administration: |
| **Continence Service:**  Bladder Symptoms:  Bowel Symptoms:  Catheter details:  Date of initial insertion of urinary catheter:  Clinical Reason for catheter: HOUDINI  Plan for removal/TWOC date:  Name of clinician for urinary catheter care:  Prior to this referral, please ensure the patient has been set up on a delivery service for their catheter supplies, given advice on how to manage their catheter and given the contact details of the teams involved in their catheter care.  For a new Male or Suprapubic catheter, please attach authorisation for change in the community. |
| **Community Rehabilitation Team (CRT):**  Please advise on which method of contact is required.  ☐ Neuro-Outpatient clinic ☐ Remote – telephone ☐ Home visit |
| **Domiciliary and Community Hospital Dietetics:**  Recent weight history:  BMI:  Height:  MUST score:  Please ensure that food first advice has been implement for at least 4 weeks prior to referral and that the following has been implemented:   * Food fortification started: * Food diary commenced:   Have supplements been started: YES / NO |
| **Diabetes Specialist Nurses:**  Current HbA1c with date:  Previous HbA1c:  Name of all diabetes medications and doses:  Diabetes review carried out in primary care prior to referral: YES/NO  Referral made for diabetes education / patient has already undertaken education: YES/NO |
| **Heart Failure:**  *Please ensure an up-to-date Echocardiogram within the last 18 month is attached with this referral.* |
| **Locality Hub:** (EMIS to EMIS referrals are the preferred referral route for all Locality Hubs)  Please confirm which hub you are referring the patient to:   |  |  |  | | --- | --- | --- | | *Ashford Hub* | *Bedser Hub* | *Thames Medical Hub* |   For the latest information about the locality hubs, how they work and how patient information is used and shared, please visit our website  <https://www.cshsurrey.co.uk/our-services/service-adults/locality-hubs-north-west-surrey-area>  Clinical Frailty Score  **Patient must score between 4-8 on the clinical frailty score.**  4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and / or being tired during the day.  5. Mildly Frail – These people often have more evident slowing and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.  6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.  7. Severely Frail – Completely dependent for personal care from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).  8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.  **Patients Frailty Score:**   |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | Please confirm if the referring GP/HCP would like to attend the MDT if required: |  |  | |
| **Medicines Optimisation in Care Homes Service (MOCH):**   |  |  | | --- | --- | | Care Home name: |  | | Care Home address: |  | | Telephone number: |  |  |  |  |  |  | | --- | --- | --- | --- | | **Residents must be a YES in one of the following categories for a member of the MOCH team to assess:** | | **Yes** | **No** | | 1 | Resident currently prescribed one of these high-risk medications:  Lithium, Oral anticoagulants e.g. Warfarin, Apixaban, Digoxin, Benzodiazepines or  Z drugs (Zopiclone & Zolpidem) |  |  | | 2 | Resident prescribed high risk medication:  Taking high dose morphine or equivalent of more than 40mg total daily dose per 24 hours.  <https://www.sps.nhs.uk/wp-content/uploads/2018/06/Dose-equivalence-and-switching-between-opioids.pdf> |  |  | | 3 | Medication reconciliation needed for:  Newly admitted resident or resident recently discharged from an acute hospital |  |  | |
| **Phlebotomy:**  *Please ensure phlebotomy requests include a blood request form.*  **URGENT Blood Test within 48 Hours** (e.g. significantly abnormal U+E, High K+, very low  Na+, TWR bloods, repeat urgent INR, ESR for possible temporal arteritis, FBC for severe  Anaemia/PR bleeding)    **Blood Tests within two weeks**(e.g.borderline U+E, bloods needed prior to referral e.g. U&E  prior to colonoscopy, Bloods to aid assessment of unwell patient)  **Blood Test within one month or a specific date, exceeding two weeks.** (HbA1C, low Na +, lipids, drug monitoring,  Pre-denosumab bloods) Therapeutic drug monitoring for specific date: Clozapine, Cortisol, Digoxin, Lithium  **Confirm patient is housebound / unable to attend clinic with transport.**  Are repeat blood tests required? YES/NO Start date: Frequency: End date: |
| **Podiatry:**  Do you consider the patient to have a limb threatening condition? YES/NO  Adults (over 18’s):  Children: |
| **Respiratory:**  *Please ensure an up-to-date spirometry with predicted values and chest X-ray is attached with this referral.*  ***(Complete all questions to avoid the referral being returned for more information)***  Respiratory Diagnosis:  MRC Score:   |  |  | | --- | --- | | Yes | No |   Currently Smoking:   |  |  |  | | --- | --- | --- | | **Ventilatory History** (if known) | **Yes** | **No** | | Modes: BIPAP |  |  | |  |  |  | | **Oxygen** | **Yes** | **No** | | LTOT, Ambulatory or both: |  |  | | If yes, please specify: (Including Flow rates) | | | |
| **Respiratory Pulmonary Rehabilitation** *(Please ensure you continue to complete if pulmonary rehabilitation is a requirement)*   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Heart Rate: |  | Resp Rate: |  | BP: |  |  |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | Is the patients BP stable? |  |  | | Is the patient on hypertensive medication? |  |  | | Does the patient have a cardiac history? |  |  | | If Yes, please specify: | | | | Is the patient clear to complete toning and cardio exercises at 85% VO2 max? |  |  | | Does the patient have any MSK issues? |  |  | | If Yes, please specify including previous injuries: | | | | Does the patient’s MSK restrict movement more than breathlessness? |  |  | | Surgical history (Including eye surgery): | | | | Is the patent clear to exercise from a surgical risk perspective? |  |  | | Are there any psychological or cognitive reasons the patient would require support for attending a course? |  |  | | If Yes, please specify: | | | |
| **Speech and Language (SLT):**  *Please ensure that the EMIS or Discharge Summary includes a detailed description of communication and / or swallow problems, including when the problem started, symptoms of swallowing difficulties, frequency and any current texture or fluid modifications.*  Further details:  Is this person at risk of hospital admission due to aspiration, chest infections, significant weight loss, dehydration or choking? YES/NO  Method of intake:   |  |  |  |  | | --- | --- | --- | --- | | PEG/ RIG | NGT | Oral feeding/drinking | PEG/ RIG + oral |     Has the patient had any chest infections (in the absence of a cold?) YES / NO. If YES, when? |
| **Tissue Viability Team (TVN):**  *(Please ensure you include as much detail regarding the wound for this referral)* |
| **Complex Wound Clinics:**  *Please include recent Doppler result and APBI if available:* |

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| **Ethnic Background** | | | | | | | |
|  | Tick |  | Tick |  | Tick |  | Tick |
| White – British |  | White & Black African |  | Pakistani |  | African |  |
| White – Irish |  | White & Asian |  | Bangladeshi |  | Any other background |  |
| White – Any Other |  | Any Other Mixed Background |  | Any other Asian background |  | Chinese |  |
| White & Black Caribbean |  | Indian |  | Caribbean |  | Any other ethnic group |  |
|  |  |  |  |  |  | Not stated |  |

Please send to CSH Single Point of Access (SPA)

Email: [CSH.SPAreferrals@nhs.net](mailto:CSH.SPAreferrals@nhs.net)

Tel: 0330 726 0333

Website:[www.cshsurrey.co.uk](http://www.cshsurrey.co.uk/)

SPA Opening Hours: (Monday-Friday: 8am - 6pm)

The following services are excluded from this referral form and pathway. Please continue to refer these services:

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| **Service** | **Referral Form** | **Referral Email Address and Contact Numbers** |
| Inpatient services for Walton and Woking Community Hospital | Direct referral form for Walton and Woking Community Hospital | [Csh.dacscommunityhospitalsbeds@nhs.net](mailto:Csh.dacscommunityhospitalsbeds@nhs.net) |
| Urgent Community Response including any falls referrals.  (for 2-hour response urgent admission avoidance) | Discharge to Assess Decision Pathway Tool | Email: [csh.nwsucr@nhs.net](mailto:csh.nwsucr@nhs.net)  Tel: 0300 3034741 |