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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Community Services - Please tick the services required** | | | |
|  |  |  |  |
| Community Nursing Team  *Housebound Service includes wound care, Palliative care needs, Catheter Care, Bowel care, Leg ulcers.* |  | Podiatry (Adults over 18s)  *Musculoskeletal Assessment; High Risk Foot/Wound care (foot ulcers); Nail surgery (in growing toenails); Routine assessment; Domiciliary visits.* |  |
| Continence  *Specialist nurses & a pelvic health physiotherapist. Management of bladder, bowel and pelvic floor conditions.* |  | Podiatry (Children’s)  *Musculoskeletal Assessment; Nail Surgery (in growing toenails), Assessment* |  |
| Community Rehabilitation Team (CRT)  *Physiotherapy and Occupational Therapy rehabilitation in the community setting.* |  | Respiratory  *General Respiratory Assessment ,Physiotherapy Assessment, Occupational Therapy Assessment, Pulmonary Rehabilitation, Ambulatory Oxygen assessment* |  |
| Diabetes Nurses  *Specialist nursing service for Diabetic patients.* |  | Speech and Language Therapy (SLT)  *Outpatient and domiciliary service including care homes.* |  |
| Dietetics -  *Service for Domiciliary visits, Care home and Community Hospital inpatient provided at Walton and Woking Hospitals.* |  | Tissue Viability Team (TVN)  *Specialist nurses providing advice on wound management.* |  |
| Locality Hubs  *An integrated physical health, mental health and care for older people with frailty.*  *Ashford , Bedser and Thames Medical Hubs* |  | Wound Clinics  *Service for Non housebound patients requiring wound care, leg ulcer care, PICC line flushes and removal of chemotherapy.* |  |
| Heart Failure  *Specialist nursing service for Heart Failure* |  |  |  |

**Please complete the correlating sections on page 2 & 3 for each selected service where applicable.**

|  |  |
| --- | --- |
| **\*Personal Details** |  |
| Surname: | Mr Mrs Miss |
| Forename: | Date of Birth: |
| Address: | NHS No: |
| Home Telephone Number: | 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’s 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 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Ethnic Background** | | | | | | | |
|  | Tick |  | Tick |  | Tick |  | Tick |
| (A) White – British |  | ® Mixed – White & Black African |  | (J) Pakistani |  | (N) Africa |  |
| (B) White – Irish |  | (F) Mixed – White & Asian |  | (K) Bangladeshi |  | (P) Any other background |  |
| ® White – Any Other |  | (G) Mixed – Any Other |  | (L) Any other Asian background |  | ® Chinese |  |
| (A) Mixed – White & Black Caribbean |  | (H) Indian |  | (M) Caribbean |  | (S) Any other ethnic group |  |

|  |
| --- |
| **\*Reason for Referral:** |
|  |
| **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.**

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

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

|  |  |
| --- | --- |
| **\*Referrer Details:** | |
| Referrer Name & Organisation: |  |
| Referrer’s Telephone Number: |  |
| Referrer’s Email Address: |  |
| Date of Referral: |  |

|  |
| --- |
| **\*Service referred to: \****Please ensure the field below is completed for the service you are referring to.* |
| Community Nursing Team:  *Please ensure all Phlebotomy requests include a blood form.*  Date first visit required: |
| **Continence Service:**  Reason for Referral:   |  |  |  |  | | --- | --- | --- | --- | | *Bladder Symptoms* | *Bowel Symptoms* | *Prolapse with Bladder or Bowel Symptoms* | *Pelvic Pain* | | *Pelvic Floor weakness* | *Prolapse* | *Other*  *(Please specify)* |  | |
| **Community Rehabilitation Team (CRT):** |
| **Domiciliary and Community Hospital Dietetics:**  Recent weight history:  BMI:  MUST score :  Please ensure that food first advise 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 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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* |   Explicit Consent:  The patient has received an explanation of the Hub service and the range of health, mental health, social care and voluntary sector organisations are involved.  This has included an explanation that the patient’s full GP record will be made available to staff operating within the Hub and that information will be shared between Hub providers and with other relevant health, mental health and social care services in order to provide the Hub service. The patient has had the opportunity to view supporting information if they wish (e.g. Hub leaflet and 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 Hub referral and associated information sharing.   |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | Explicit patient consent has been gained for the Hub 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 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 : |
| **Heart Failure**  *Please ensure an up-to-date Echocardiogram within the last 18 month is attached with this referral*. |
| **Podiatry**  Adults (Over 18’s):  Children’s: |
| **Respiratory**  *Please ensure an up-to-date spirometry and Chest X-ray is attached with this referral.*  **Ventilatory history ( if known ):**   |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | ITU admission |  |  | | Modes: BIPAP |  |  | | CPAP |  |  |  |  |  |  | | --- | --- | --- | |  | **Yes** | **No** | | Oxygen |  |  | |
| **Diabetes Nurses:**  *HbA1c Level:* |
| **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 (TVN):**  *Infective status if known (e.g. MRSA+ve):*  Advice on dressing selection , Unexplained rapid Deterioration ,Wound Static/Non-healing ,  Patient concordance ,Leg ulcer assessment , Advice on pressure ulcer management , Category 3 or 4 pressure ulcer , Wound failed to heal following 6 weeks of optimal treatment  Other |
| **Wound Clinics**  *Please include recent Doppler result and APBI if available:* |

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 to:

|  |  |  |
| --- | --- | --- |
| **Service** | **Referral Form** | **Referral Email Address** |
| Inpatient Services for Walton and Woking Community Hospital | Direct referral form for Walton & Woking Community Hospital | [Csh.dacscommunityhospitalsbeds@nhs.net](mailto:Csh.dacscommunityhospitalsbeds@nhs.net) |
| Rapid Response including any Falls referrals | Discharge to Assess Decision Pathway Tool | [csh.nwsrapidresponse@nhs.net](mailto:csh.nwsrapidresponse@nhs.net) |