**Discharge Support Service:  Community Support Referral form**

Age UK Bucks Community Support Service is for people aged 18+ living in Buckinghamshire. We are a short-term service providing support in the home with shopping, light domestic tasks, advice and signposting. As a volunteer dependent service we must prioritise those with the highest need – people that live alone or with others that are not able to provide support. Our focus is to help prevent delays to discharge and the need for further health and social care support and reduce hospital re-admissions.

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| **GDPR Regulations Consent: (*Please circle as appropriate)*** | | |
| * Please confirm that we have the individuals consent to keep their details securely on our computerised system | YES | NO |
| * How can we get in touch? | EMAIL | LANDLINE |
| MOBILE | LETTER |
| * Is the individual aware of this referral and do they give consent for any support offered by this service? | YES | NO |

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| Name: Preferred name:  Date of birth: NHS Number:  Ethnicity\*: Gender:  Country of Birth: Religion:  Sexual Orientation: Employment Status:  Number of Children: Marital Status: |

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| Home address:  Postcode: | Telephone no:  Preferred contact: |

**\*Ethnicity.** Please use a code from this list. (Used for statistical purposes only). 1: White UK. 2: Black African. 3: Black Other. 4:Bangladeshi. 5: Mixed White/Asian. 6: Chinese. 7: White Irish. 8: British Black. 9: Indian. 10: Mixed White/Black. 11: Mixed Other. 12: White other. 13: Black Caribbean. 14: Pakistani. 15: Mixed White/African. 16: Any other ethnic group. 17: Withheld.

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| Name of referrer:  Contact details of referrer: | Position of referrer:  Date of referral: |
| Reason for referral. Please also include any known risks: | |
| Support Required. Please tick all that apply  Domestic Befriending Shopping Advice Other  Details: | |

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| Hospital/Ward: | Admission date:  Admission reason: |
| Expected discharge date: | Actual discharge date: |
| Relevant medical history (please include details on long term health conditions, sensory issues and any drug or alcohol dependency or mental health needs): | |
| Pathway Recommended by MDT | Is there a history of falls? |

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|  |  |  | Comments |
| Does the client live alone? | Yes | No |  |
| If not, do they live with other/s that are able to support them? | Yes | No |  |
| Can client mobilise independently? | Yes | No |  |
| Is there a Key Safe? | Yes | No | Number: |
| Is client able to answer the door? | Yes | No |  |
| Does the client have a pet? | Yes | No |  |
| Does the client smoke? | Yes | No |  |
| Is client receiving ongoing hospital treatment? | Yes | No |  |

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| **GP details** |
| Name & Surgery:  Telephone Number: |

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| **Please give details of next of kin or emergency contact** | |
| Name:  Address: | Their Tel No:  Email address: |
| Their relationship to the patient: | |
| Do we have their permission to contact them if necessary? | YES NO |

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| **Other agencies currently involved** (Please tick and give days where appropriate): | |
| Social Worker: | Home Carer: |
| C.P.N: | District Nurse: |
| Meal delivery service: | Regular family/friends/neighbour support/visits: |
| Day Care Attendance: | Any other regular support: |
| Please state if there is a care package due to start. Please include dates and details of care provider | |