

**Age UK Cambridgeshire & Peterborough**

**L24 SFBC Fenton Way Chatteris PE16 6TT**

**Email to:** **HDsupport@ageukcap.org.uk**

**Discharge line 01354 691896**

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| --- |
| AUK Office use only |
| Date of referral |      |
| Service user Name |  |
| Staff name  |       |
| CL No  |  |

**Hospital Discharge & Admission Avoidance Support Service**

 **REFERRAL FORM**

|  |  |
| --- | --- |
| HOSPITAL Discharged from  |  |
| Referrer name  |  |
| Referrers position/job title  |  |
| Referrer Tel No |  | Email Address |  |
| Discharge Pathway | 0 [ ]  1 [ ]  |
| OR at home ADMISSION AVOIDANCE [ ] Referrer details as above  |
| **PATIENT DETAILS** |
| **Title** |  | **First Name** |       | **Surname** |  |
| Known As |       |
| Home Tel No |       | Mob No  |       |
| Home Address |       |
| Tenure |  | Living Arrangements |  |
| **Date of birth**  |       |
| **Area** |  |
| Marital Status |  | Gender  |  |
| Ethnic Group  |  | Religion |  |
| Has client given permission for this referral? [ ]  |
| **NEXT OF KIN DETAILS**  |
| Name |       | Relationship |       |
| Address |       |
| Telephone No  |       |
| **OTHER CONTACTS i.e NEIGHBOUR – FRIEND**  |
| Name/relationship |       |
| Contact details  |       |
| **MEDICAL DETAILS** |
| GP Surgery  |       |
| **Reason for hospital admission**  |       |
| Length of stay (LOS) |   |
| COVID Symptoms |  YES [ ]  NO [ ]  |
| COVID 19 Test |  Positive [ ]  Negative [ ]  |
| Property empty for more than 72H |  YES [ ]  NO [ ]  |
| Current and medical history. Who is involved eg support worker, social worker – please detail contact numbers needed |        |
| Care package  | IF SO, WHAT ARE THE CARE ARRANGEMENTS:       |
| Patients current location (ward, home etc)  |   |
| Do we need to provide transport YES [ ]  NO [ ]  |
| **REASON FOR REFERRAL please record all details needed from the referrer re what is the objective is and what is the current situation:** |
| When do we need to visit?      **PRIOR TO VISIT :**Does patient need food? if so, are there any dietary requirements      Does patient need other urgent items eg incontinence pads      How is patients’ mobility?      Other pre visit information: |