

**Age UK Cambridgeshire & Peterborough**

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

**Email to:** [**HDsupport@ageukcap.org.uk**](mailto:HDsupport@ageukcap.org.uk)

**Discharge line 01354 691896**

|  |  |
| --- | --- |
| 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: | | | | | | | | | | | | |