

Postcode Boundary

Community Discharge Coordination Centre: Administration Community Referral First Contact Sheet

<p><i>Is this referral for a rehab service or RAPID RESPONSE? If for Rapid transfer to 0117 9030202 and inform referrer of number for next time Is patient medically stable to participate in rehab programme within 48 hours? If No re-refer when medically stable (unless in hospital).</i></p>			
NHS No:	RIO No:	PARIS No:	ICD10 Code:
Date of Referral:	Referrer Name, Profession, Location, Contact No/Bleep:		
Time of Referral:			
Patients Name (incl Title):	Assessment in hospital or in the community? complete appropriate section		
	*Hospital		
	Hospital:	Consultant:	
DOB:	Ward/Gate:		
Telephone Number:	Medically fit for discharge: Yes / No	Hospital Number:	
Consented to referral: Yes / No / Best Interest	EDD:		
Address(incl. postcode):	*Community		
	Patient current location:	Details of Advocate to be present on Ax:	
Next Of Kin Name:	If patient is still in hospital are they medically fit for discharge: Yes / No EDD:	Does patient live alone: YES / NO	
Relationship:		Any problems with access:	
Contact Tel:			
GP & Surgery:	Has the patient recently been discharged from hospital: Yes / No Date: Hospital:	Any risks in home environment:	
Tel No:		Do CM's need to visit in pairs: YES / NO	
Ethnicity: Interpreter required: Y / N IF YES - Language	Reason for admission:	Keysafe number: YES / NO (If yes enter no. on RIO not on form)	
<u>Details of presenting condition/Reason for hospital admission:</u>			
<u>Reason for Referral – including Rehab Needs/Goals/Previous Ability:</u>			
<u>Has the patient got a package of care in place? - IF YES - Frequency?</u>			
<u>Has the patient been referred to the Reablement service?</u>			
<u>Are there any Mental Health or Cognitive concerns: YES / NO If 'YES' please state:</u>			
<i>For admin office use only:</i>	Alerts: CF/P/R/PCT/G	GP Medical Consultation History Requested: Yes / No	
	CDC Fax Number: 0117 3423052		