|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Patient Details* | | | | | | | | | | ***Admission Details*** | | | |
|  | | | | | | | | | | **Ward Name:** | | | |
|  | | | | | | | | | | **Ward Ext Number:** | | | |
| Please use a patient label | | | | | | | | | | **Admission Date:** | | | |
|  | | | | | | | | | | **Planned/Emergency (please circle)** | | | |
|  | | | | | | | | | | Likely length of stay | | | |
| Patient Consent Obtained for Social Care referral | | | | | | | | | | **Consultant:** | | | |
| **Need identified for (please tick boxes which apply)** | | | | | | | | | | **Next of Kin/Carers details** | | | |
| **Lives alone** |  | **Over 65** | |  | | Advice/information only | |  | |  | | | |
| **Restart/Increase care** | | | |  | | **Adult protection issues** | |  | |  | | | |
| **Mental Health needs** | | | |  | | **New care package** | |  | |  | | | |
| **Night time care** | | | |  | | **Nursing Need Identified MNNA attached** | |  | |  | | | |
| Any further information | | | | | | | | | | Is it thought likely that the patient isSelf funding/paying for own careYES/NO/UNSURE **(please circle)** | | | |
|  | | | | | | | | | |
|  | | | | | | | | | | **Estimated discharge date** | | | |
|  | | | | | | | | | |  | | | |
|  | | | | | | | | | |  | | | |
| ETHNICITY | | | | | | | | | | | | |
| White | | |  | | Asian or Asian British | | | |  | | Other Ethnic Groups |  |
| British | | |  | | Indian | | | |  | | Chinese |  |
| Irish | | |  | | Pakistani | | | |  | | Any other Ethnic group |  |
| Any other White background | | |  | | Bangladeshi | | | |  | |  |  |
|  | | |  | | Any other Asian background | | | |  | | Not Stated |  |
| Mixed | | |  | |  | | | |  | |  |  |
| White & Black Caribbean | | |  | | Black or Black British | | | |  | |  |  |
| White & African | | |  | | Caribbean | | | |  | |  |  |
| White & Asian | | |  | | African | | | |  | |  |  |
| Any other mixed background | | |  | | Any other Black background | | | |  | |  |  |
| **Date referral completed** | | | | | | | **Date faxed to Hospital Disharge Team** | | | | | | | |
|  | | | | | | |  | | | | | | | |
| **Signature of Medical Professional** | | | | | | | **Please print name** | | | | | | | |
|  | | | | | | |  | | | | | | | |
| **FOR WARD USE ONLY** | | | | | | | | | | | | | | |
| **When did Social Service make contact regarding this referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | |
| **CHC Checklist is needed not and a copy sent to the Hospital Discharge Team on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | |