| **Access to Care – Clinician Screening Tool** | | | | | | | | | | | **Case Number: (AtC use only)** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient’s Name:**  **………………………………………………………………………**  **Patient’s Address:**  **………………………………………………………………………**  **………………………………………………………………………**  **Patient’s Telephone No: ………………………………………**  **GP …………………………………………………………………**  **NHS Number: ……………………………………………………** | | | | | **Name of Referrer:** | | | | | **Referrer’s Telephone No:** | | | | | | **Is patient aware of referral?**  **Yes / No** | | **E.D.D** | |
| **PMH:** | | | | | **Medication:** | | | | | | **Next of Kin:** | | **Allergies:** | |
| **Ward:** | | | | | | **Diagnosis:** | | | | **Symptoms/problems/duration:** | | | | |
| 1 | **What’s the patient’s current mobility?** | Independent | Ax1 | Ax2 | | | Supervision | | Hoist | | | | | Wheelchair Dependent | | | Not yet mobilised | | Safe?  Yes / No |
| 2 | **What walking aid is the patient currently using?** | Independent | Walking Stick | Zimmer Frame | | | Wheelchair | | Crutches | | | | | Pulpit/Gutter Frame | | | Delta Frame | | Swedish Trolley |
| 3 | **What was the patient’s previous mobility?** | Independent | Ax1 | Ax2 | | | Hoist | | Wheelchair Dependent | | | | | Comments: *e.g stairs, outdoor mobility* | | | | | |
| 4 | **What walking aid was the patient using previously?** | Independent | Walking Stick | Zimmer Frame | | | Wheelchair | | Crutches | | | | | Pulpit/Gutter Frame | | | Delta Frame | | Swedish Trolley |
| 5 | **Is the patient able to transfer?**  **(bed/Toilet/Chair)** | Independent | Ax1 | Ax2 | | | Supervision | | Sliding Board | | | | | Hoist | | | Comments: (consider night needs) | | |
| 6 | **Is there a history of falls?** | Yes/No Unknown | **What is the frequency/cause of the falls?** | *e.g. 3 falls in the last 2 weeks, mechanical* | | | | | | | | | | | | | Is the patient known to falls clinic? | | Yes / No  Unknown |
| 7 | **Are there any personal care issues?** | Yes/No | Independent | Ax1 | | | Ax2 | | Prompt  Only | | | | | Set up  Only | | | Previous Ability? | | |
| 8 | **Are there any meal preparation issues?** | Yes/No | Independent | Carer provides | | | Family provide | | Has kitchen assessment been carried out  Yes / No | | | | | | | | Other: | | |
| 9 | **What type of accommodation does the patient live in?** | House | Bungalow | Upstairs flat | | | Ground floor flat | | Nursing / Residential Home | | | | | Comments *ie. Warden controlled, access problems (inc. lift) , where the patient sleeps, location of toilets.* | | | | | |
| 10 | **Are there any incontinence issues?** | Yes/No | Urinary  Incontinence | Faecal  Incontinence | | | Doubly  Incontinent | | How is it managed?  Urinary catheter / convene / pads / stoma | | | | | | | | Comment Box: Self care? | | |
| **Patient Name:** | | | | | | | | | | | | **DOB:** | | | | | | | |
| 11 | **Is there an existing care package?** | Yes/No | Comments: e.g. *frequency of visits, name of care agency, known re-start date* | | | | | | **Are they self-funding?** | | | | | Yes/No | | | N/A | | Unknown |
| 12 | **Are there any other services involved?** | Yes/No | Comments: *e.g family, cleaner, lifeline, MHT, shopping* | | | | | | **Does the patient have any continuing healthcare needs?** | | | | | Yes/No  (Consider Assessment) | | | Comments: | | |
| 13 | **Is the patient normally self medicating?** | Yes / No | **Does the patient have a Dosette Box? Yes / No** | | | | | | **Who fills the Dossette Box? Self / Family / Chemist** | | | | | | | | | | |
| 14 | **Are there any dietary issues?** | Yes/No | Independent  Feeding | Needs feeding | | | Oral fluids only | | Ng/peg feed | | | | | Swallowing problem | | | IV/SC Fluids | | Other: |
| 15 | **Does the pt have any wounds or ulcers?** | | Intact Skin | Ulcer | | Wound | | Where / Type / Grade | | | | | Does the patient require any pressure relief equipment? Yes / No.  What? | | | | | | |
| 16 | **Which dressings are being used and how often are they changed?** | | |  | | | | | | | | | | **Is there a supply of dressings?** | | | Yes/No | | Requested |
| 17 | **Does the patient have any current or longstanding infections?** | Yes/No | **What Infection is present?** |  | | | | | **What treatment has been given or started?** | | | | |  | | | | | |
| 18 | **Is the patient an infection risk?** | Confirmed Risk | Suspected Risk | No Known Risk | | | **Does the patient require a side room/isolation?** | | Yes/No  N/A | | | | | Details: | | | | | |
| 19 | **Are there any risks or alerts the staff should be aware of?** | None | Violence | Animals | | | Alcohol/Drugs | | Vulnerable Adult | | | | | Other | | | Comments: | | |
| 20 | **Does the pt have any degree of confusion?** | Alert and Orientated | Mild Confusion | Moderate Confusion | | | Wandering | | Aggressive | | | | | Dementia | | | Comments: | | |
| 21 | **Does the patient have any communication difficulties?** | Yes/No | Vision | Hearing | | | Speech | | Other | | | | | Comments: | | | | | |
| 22 | **Are there any active rehab goals?** | Yes/No | Comments: *e.g. Rehab goals, area of need – list of broad areas.* | | | | | | | | | | | | | | | | |
| **Further Comments: ie. Medical status, any relevant information.** | | | | | | | | | | | | | | | | | | | |
| **Triaged by: (SIGN & PRINT)** | | | | | | | | | | | | **Date:** | | | | | | | |

**Specific reports may be required to support timely transfer of care, ie MHT liaison report, OT, PT, pressure risk, Bristol bowel stool chart, dressings, care plan.**

**Please fax this referral form to the Discharge Team on 01722 425148 Mon-Fri. Discharge Team Telephone No: ext 4292 or direct 01722 429292**

**Referrals outside of office hours/weekends/BH fax direct to AtC Fax No: 0845 120 4339 AtC Telephone No. 0845 120 4338**