FAX 1 – REFERRAL (Assessment Notification to Social Services)

(Section 2 of Community Care Delayed Discharges Act 2003)

Planned and Emergency Admissions

Patient Details	***Admission Details***
Please use a patient label	**Ward Name:**
	Ward Ext Number:
	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 is** **Self funding/paying for own care** **YES/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 Discharge Team**
Signature of Medical Professional	**Please print name**

FOR WARD USE ONLY

When did Social Service make contact regarding this referral

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CHC Checklist is needed and a copy sent to the Hospital Discharge Team on

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