|  |  |
| --- | --- |
|  |  |

**Referral to the Acute Medical Unit**

Salisbury District Hospital,

Odstock Road,

Salisbury,

SP2 8BJ

Tel: 01722 349726

Please send by eRS: sft.acutemedicalreferrals@nhs.net

|  |  |  |  |
| --- | --- | --- | --- |
| **Referred to:** |  | **Time:** |  |

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  | Sex |  |
| Date of birth |  |  |  |
| AddressPost Code |  | Home tel. no. |  |
| Other tel. no: |  |
|  |  |

**Referral Details:**

|  |  |
| --- | --- |
| Referring clinician |  |
| GP Practice |  | Practice Tel number |  |
| Practice Fax number |  |

**Co Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required? | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |  | Learning Disability:  |  |
| Hearing: |  | Other disability needing consideration:  |  |
| Vision: |  |
|  |  |  |  |  |  |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

**Clinical details:**

|  |
| --- |
| **Presenting complaint / Reason for referral:** |
| **Relevant history, examination, and investigations:** |
| **Past Medical History:** |
| **Repeat Medication** (Name, dose, and frequency): |
| **Acute Medication** (especially recent antibiotics): |

**Relationships**

|  |  |
| --- | --- |
| Carer |  |
| Care Co-ordinator |  |
| Next of Kin |  |
| L.Power of Attorney |  |
| Other |  (eg family, medical teams, nurses, palliative care) |

**Social and other details:**

|  |
| --- |
| Background |
| Allergies: |  |
| Occupation: |  | Drives a car: | Yes [ ]  No [ ]  Don’t know [ ]  |
| Previous heavy alcohol use: Units |  | Smoking history:Pack year history |  |
| History of falls: | Yes [ ]  No [ ]  Don’t know [ ]  | History of Dementia: | Yes [ ]  No [ ]  Don’t know [ ]  |
| Mobility (Please circle as appropriate): |
|  Independent [ ]  Walking Stick [ ]  Walking Frame [ ]  Other:  |
| Infection risks: |
| MRSA positive: | Yes [ ]  No [ ]  Don’t know [ ]  | Recent D+V: | Yes [ ]  No [ ]  Don’t know [ ]  |
|  |
| Risk of extended hospital admission: | Yes [ ]  No [ ]  Don’t know [ ]  |
| Known to mental health team | Yes [ ]  No [ ]  Don’t know [ ]  |
| Known to palliative care | Yes [ ]  No [ ]  Don’t know [ ]  |
| Known to ADAS | Yes [ ]  No [ ]  Don’t know [ ]  |
| \*If Yes, please provide further detailsHome environment: |
| Accommodation:(tick as appropriate) | Own home [ ]  | Rented [ ]  | Warden assisted [ ]  | Residential [ ] Home  | Nursing [ ] Home  |
| House [ ]  | Bungalow [ ]  | Downstairs flat [ ]  | Upstairs Flat [ ]  | Other: |
| Others in household (health of others): |  |
| Other input a home (Carers, District Nurse, Community Matron etc.) |  |
|  |
| Other issues/concerns/details: |

Many Thanks

Name: **Date:**

Sent electronically, no signature required