| **Access to Care – Clinician Screening Tool** | **Case Number: (AtC use only)** |
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| **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 / NoUnknown |
| 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 outYes / 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 | UrinaryIncontinence | FaecalIncontinence | DoublyIncontinent | 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 | IndependentFeeding | 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**