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

**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](mailto:sft.acutemedicalreferrals@nhs.net)

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

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Sex |  |
| Date of birth |  |  |  | | |
| Address  Post 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 details  Home 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