DGSS Adult Community Service Referral Form

Please take the time to complete all sections of the referral form as incomplete referrals will not be accepted and returned to referrer. Please send completed referrals to VCL.DGSS-CCC@nhs.net

DGS & Swale Services		DGS Service	
Rapid Response Service Crisis Response	☐	Cancer Service	☐
Community Nursing Service	☐	Community Neuro Rehab Service	☐
Community Phlebotomy Service	☐	Falls Service	☐
Community Matrons Service	☐	Heart Failure Service	☐
Continence Service	☐		
Diabetes Service	☐	**Swale Service**	
Intermediate Care (Home Based Therapy)	☐		
MDT Co-ordination	☐	Cardiac Service	☐
Oxygen Service	☐	Wound Medicine Centre	☐
Podiatry Service	☐		
Speech & Language Therapy Service	☐		
Respiratory Service	☐		
Tissue Viability Service	☐		

Rapid Response & Phlebotomy		All Other Services	
2 Hour Urgent Response (**Rapid Response only** for D2A or Admission Avoidance)	☐	Routine (1 – 18 weeks)	☐
24 Hours **(Phlebotomy only)**	☐		
48 Hours **(Phlebotomy** only)	☐	Other (Specify Date):	☐
72 Hours **(Phlebotomy only)**	☐		

Patient Details	
Surname:	Mr / Mrs / Miss
Forename:	Date of Birth:
Known as:	Gender:
Address:	First Language:
	Home Telephone Number: Mobile:
Postcode:	NHS Number:

GP Information	
GP Surgery:	GP Telephone no:
GP Name:	GP Email:

Next of Kin	
Next of Kin Name:	Next of Kin: Relationship to patient:
Next of Kin Contact Number:	Other Contact details:

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Patient Information	
Has consent been obtained for this referral? Please detail 3rd party consent if applicable.	YES/NO
Does the patient have any communications needs for spoken communication?	YES/NO (if Yes please specify)
Does the patient have any communication needs for written communication?	YES/NO (if Yes please specify)
Has the patient expressed a preferred method of contact?	YES/NO (if Yes please specify)
Is the patient able to attend a clinic appointment?	YES/NO (if Yes please specify)
Do we need to contact you regarding access or Key Safe details?	YES/NO
Are there any alerts relating to this patient?	YES/NO (if Yes please specify)

Social Care arrangements:			
Lives alone in own home ~~independently~~	☐	Long term nursing care	☐
Lives with family/spouse with no formal care	☐	Warden controlled accommodation	☐
Lives in own home with care package in place	☐	Currently inpatient in acute/community bed	☐
Long term residential care	☐	Confirm Ward if YES to above:	☐

Referral Information	
Reason for Referral (specific details):	
Diagnosis:	Known Allergies:
Relevant clinical Information: Summary care record attached yes/no	*Current Medications:* Medication list attached yes/no
Infection Status (Current & historic), incl. MRSA:	Pressure Ulcer: YES / NO
Please attach copy of the summary care record / list of current medications for the last three months to this referral.	
Please share results of investigations/procedures, scans and any microbiological information or signs of infection where appropriate.	

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Referrer Details:	
Referrer Name:	Referrer's Telephone Number:
Referrer Designation:	Referrer's Email Address:
Referrer Organisation:	Date of Referral:

Additional Information Required:

Cardiac Service Swale (Heart Failure Referrals)					
BMI:	☐	BNP Result:	☐	ECG	☐
Community Neuro Rehab DGS Patient Rehab Goals					
Cognitive rehab	☐	Dietic	☐	Speech & Language therapy	☐
Mobility	☐	Upper Limb	☐	Other:	☐
Community Nursing - Medical Devices					
Catheter	☐	PICC	☐	Date of Insertion	☐
Portacath	☐	PEG	☐	Date Change Due:	☐
Cannula	☐	Size/Type	☐		
Diabetes DGSS					
Height (cm):		eGFR (ml/min/1.73m^2):		HbA1c (mmol/mol) within last 3 months:	☐
Weight (Kg):		BMI (Kg/m^2):		Urine ACR:	
Heart Failure Service DGS					
BMI:	☐	BNP Result:	☐	ECG:	☐
Oxygen Service DGSS					
Current Smoker Y/N	☐	Optimum inhaler therapy reached: Y/N	☐	SpO2 ≤ 92% on air at rest: Y/N (on two consecutive occasions)	☐
Evidence of desaturation on exertion? Y/N	☐	Free from antibiotics & steroids (for chest infection) for 8 weeks Y/N	☐	Date of last Chest Infection:	☐
Echocardiogram report available	☐				
Podiatry Referral Reason:					
Anticoagulant therapy	☐	Health Education	☐	Pathological Nail Care	☐
Biomechanical Assessment	☐	Immunosuppressed	☐	Peripheral Neuropathy	☐
Corns/Callous	☐	Ingrowing Toenail /infection	☐	Peripheral Vascular Disease	☐
Diabetes NICE Foot Risk Category:	☐	MSK/Biomechanical assessment	☐	Podiatric Surgery Assessment	☐
Foot Ulceration/Pressure sore Category:	☐	Nail Surgery Assessment	☐	Rheumatoid Arthritis	☐
Foot Wound	☐	Pain	☐	Serious neglect (short term)	☐

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Respiratory Service DGSS - Respiratory Assessment Service					
Spirometry report attached	☐	FVC:	☐	Recent chest x-ray results	☐
FEV_1:	☐	FEV_1 / FVC ratio:	☐	CT Report (ILD/Pulmonary Fibrosis and Bronchiectasis)	☐
Speech & Language DGSS - Does the patient have the following symptoms:					
Coughing	☐	Choking	☐	Loss of food / fluids from the mouth	☐
Difficulty Chewing	☐	Difficulty Swallowing	☐		
Tissue Viability & Wound Care					
TVN referrals may be delayed and/or declined without the appropriate information provided as requested below					
1. Wound assessment - no older than 1 week old, to include exact location of wound current dressing plan.	☐	3. Lower limb and Doppler results if a wound to the lower limb (TVN service does not provide a doppler service for basic assessment) – if these cannot be provided please advise why:	☐	5. Recent related clinic letters / referrals and hospital discharge summaries	☐
2. Previous wound history and dressing treatment plans, GP summary, PMH and medication.	☐	4. Recent blood sampling and wound swab results, if signs of infection	☐	6. Colour photography must be provided from all care/nursing homes and GP practices	☐

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