South Warwickshire NHS
NHS Foundation Trust

D2A PILOT
REFERRAL DISCHARGE SUMMARY

Title - Mr, Mrs, Miss, Other (please state)……

Patients Name……

Address……

……

D.O.B…… Age…… Sex: Male / Female

Marital Status: M / S / D / W / Other Lives alone Y / N

Previous Registered GP Name……

GP Practice……

Please tick

Pathway 2 ( )

Pathway 3 ( )

D2A NH

Avon CT ( )

Alveston ( )

K'worth ( )

Next of Kin:

Name……

Relationship……

Home Tel No:

……

Mobile Tel No:

……

Work Tel No: ……..

Clinical Condition (Circle answers as appropriate)

Date of Admission to Warwick Hospital……

Reason for Admission, Diagnosis and treatment……

……..

……..

……..

……..

Current Medication – Refer to Drug and Discharge Summary.

Outpatient Appointment / Follow-up……..Y / N

If yes please state……

Previous Medical History

……

……

……

……

……

……

……..

Allergies……Y / N

If yes, please state……

Advance Care Directive

Advance care Directive in place: Y / N

(If yes ensure copy goes with patient)

Transferable DNAR Y / N

(If yes ensure the copy in the sleeve goes with the patient)

Care needs

Cognition and Behaviour

Is there Cognitive Memory Impairment	**Y / N**
Current confusion / walking with purpose	**Y / N**
Risk to self or others	**Y / N**
Episodes of Delirium / Altered behaviours	**Y / N**

If yes give brief description……

……..

……

Diagnosis of Dementia or Alzheimer's Disease	**Y / N**

Mild to Moderate – Moderate to severe (please circle)

If yes give brief description……

……

……

……

Communication

Difficulty with hearing	**Y / N**
Sight Impairment	**Y / N**
New or existing problems speaking	**Y / N**

Describe……

……

Personal Care

Assistance of 1 carer	**Y / N**
Assistance of 2 carers	**Y / N**

Moving and Handling		**Support prior to acute admission**
Transfers: independently / with 1 carer / with 2 carers	**Y / N**	.....
Mobilises with ZF / WZF / Gutter frame / sticks	**Y / N**	.....
(please circle above)		.....
Requires Hoist / Turntable	**Y / N**	.....
Any special positioning requirements	**Y / N**	.....
Requires Splints	**Y / N**	.....
Requires Hydro Tilt in Space chair *	**Y / N**	.....
		*Must be authorised by Discharge Team Manager

Nutrition		**Infection Control**	
Special Dietary Requirement	**Y / N**	Norovirus	**Y / N**
If yes state:		Clear 48 hours	**Y / N**
.....		D & V	**Y / N**
.....		Clear 48 hours	**Y / N**
.....		E.Coli	**Y / N**
Has Swallowing Problems	**Y / N**	MRSA	**Y / N**
Requires NGT / PEG Feeding	**Y / N**	Barrier Nursing required	**Y / N**
Requires assistance Eating and Drinking	**Y / N**	.....	
Nutritionally at risk – may need monitoring	**Y / N**		

Elimination		Recommendation by MDT / Long term goal whilst at acute:	
Continent of Urine	**Y / N**	Usual place of residence	**Y / N**
Continent of Faeces	**Y / N**	Residential Home	**Y / N**
History of Constipation	**Y / N**	Nursing Home	**Y / N**
Stoma	**Y / N**	EMI RH	**Y / N**
Urethral / Supra Pubic Catheter (If yes circle appropriately)	**Y / N**	EMI NH	**Y / N**
		Patient/family goal.....	

Skin Integrity		**Therapy Goals on discharge: (Physio/OT to advise:**
Skin Intact	**Y / N**	**Physio:**.....
Pressure Ulcers present	**Y / N**	.....
Pressure relieving mattress required	**Y / N**	.....
Site, grade and treatment **(photocopy TV careplan and fax)**.....		**OT:**.....
.....		.....
.....		.....

Referrers Signature.....**Referrers Name(Print)**.....

Referrers Designation.....**Date**.....

CONSENT FORM COMPLETED AND PATIENT HAS A COPY Y / N .....