**Integrated Care Centre – Frailty Support Team (ICC-FST)**

**Care Home/Nursing Home Resident – Comprehensive Geriatric Assessment Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

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| --- | --- |
| Name of Referrer:  | Date of Referral:  |
| Job Title:  |
| Address & contact number/email of referrer:  |
| **PATIENT DETAILS** |
| Registered GP:  | GP Practice Address:  |
| Title:  | Forename:  | Surname:  | Known as:  |
| Date of Birth:  | NHS Number:  |
| Gender: | Ethnicity: |
| Religion: |
| Address:  |
| Patient home number:  | Patient mobile number: |
| Preferred contact number: Home [ ]  Mobile [ ]   | Email address: |
| Lives alone/carers/nursing home/residential home: | Next of Kin/Carer/Emergency contact: |
| Consent to contact via SMS | Yes [ ]  | No [ ]  |
| Consent to contact via Email  | Yes [ ]  | No [ ]  |
| Consent to share medical information:  | Yes [ ]  | No [ ]  |
| Translator required: | Yes [ ]   | No [ ]  | Language required\*: |
| Chaperone required: | Yes [ ]   | No [ ]  |
| Accessible information needs:  | Yes [ ]   | No [ ]   | Detail needs: |
| Diagnosis:  | Client aware of diagnosis?  | Yes [ ]  | No [ ]  |
| Are there any other services involved in patient’s care | Yes [ ]   |  No [ ]  | Don’t know [ ]  | **(If yes give details)** |
| **SUPPORTING INFORMATION** |
| Is there a Lone working risk?  | Yes [ ]  | No [ ]  |
| Is there a Safeguarding risk?  | Yes [ ]  | No [ ]  |
| Has the patient given consent for the referral?  | Yes [ ]  | No [ ]  |
| Any concerns re Mental Capacity?  | Yes [ ]  | No [ ]  |
| **ReSPECT** document in place?  | Yes [ ]   |  No [ ]  | **(If yes give details)** |
| Smoking: | Yes [ ]   |  No [ ]  | Don’t know [ ]  |
| **REFERRAL DETAILS**  |
| **Please complete details of referral criteria: -** |
| **New resident within previous 7 days**   | Yes [ ]   | No [ ]  **(If no please complete next section)** |
| Patient identified with one or more of the following complexities and requiring specialist input: -**(Please tick as applicable).** |
| Behavioural issues requiring MDT approach, including those being referred for 1:1 care within the home | Yes [ ]   |  No [ ]  |
| Multiple falls despite Falls team intervention  | Yes [ ]   |  No [ ]  |
| 3 or more ED attends or admissions in past 3 months  | Yes [ ]   |  No [ ]  |
| 2 or more analgesics (not including paracetamol)  | Yes [ ]   |  No [ ]  |
| Complex feeding issues or support for decision making  | Yes [ ]   |  No [ ]  |
| Second opinion for complex advanced care planning  | Yes [ ]   |  No [ ]  |
| Second opinion for diagnostic uncertainty  | Yes [ ]   |  No [ ]  |
| **Referral criteria:**The service will provide MDT face to face assessment within the care home setting for* Any individual resident identified with complexities requiring specialist input (see below referral criteria)
* All residents permanently new to care homes within previous 7 days regardless of clinical presentation
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| **Eligibility criteria:**Patients MUST be registered with a either a GP or East Riding GPLiving in residential/nursing care Electronic record sharing will need to be in place at the time of referral**Where urgent advice/support is required please contact the ICC-FST on 01482 450078 (Mon-Fri 8am-6pm) to speak to either a consultant or GPwER in Frailty**  |

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***