| **Homeless Health COVID-19****Referral form for Hospital Discharge – Acute Care****(including inpatients, emergency department and mental health wards)**  | NHS Patient Identifying Number (if known): Family name: Given name(s): Phone number:Current address/known address (if avail.): Date of birth: Sex: [ ]  M [ ]  F [ ]  I |
| --- | --- |
| **Date:**  | **Referring Hospital:**  | **Referrer contact details:** |
| This information is confidential and is provided for medical purposes  |
| TRANSFER TO:1. **COVID-CARE** – (symptomatic or positive, or less than 14 days since onset of illness)
2. **COVID-PROTECT** – (vulnerable but COVID negative / asymptomatic – no symptoms in last 14 days)

Send form to: **hlp.hhc19hoteldischarge@nhs.net**Placement in the hotels is a last resort and a short-term measure. You should also make a **duty to refer** for anyone who is homeless or threatened with homelessness. Always contact your discharge coordinator and pursue normal housing channels as well.**Please discuss rules of self-isolation with the patient** |
| **Original reason for admission:** |
|  |
| **Brief discharge summary with key conditions and ongoing care needs (cut and paste as necessary):** |
|  |
| **Registered General Practitioner** |
|  [ ]  Yes [ ]  No | Name/Contact details:Address:Phone Number:  |
| **Known COVID + ve** |
| [ ]  Yes [ ]  No | If yes, date symptoms began:Currently symptomatic:[ ]  Yes [ ]  No |
| **Unknown COVID Status** |
| Current COVID symptoms:  | [ ]  Yes [ ]  No | If yes, date symptoms began:Awaiting test result: |
| Were they admitted with symptoms: | [ ]  Yes [ ]  No | If yes, did symptoms start more than 14 days ago: |
| **Medical and other vulnerabilities:** |
| [ ]  >55 | [ ]  Pregnant | [ ]  Asthma | [ ]  COPD/bronchitis | [ ]  Chronic Heart Disease |
| [ ]  Diabetes  | [ ]  Epilepsy | [ ]  Chronic Kidney Disease | [ ]  Chronic Liver Disease | [ ]  Chronic Neurological Disease (PD/MND/LD etc) |
| [ ]  Splenic Dysfunction/removal | [ ]  HIV/AIDS | [ ]  Cancer Treatment | [ ]  Weakened Immune system | [ ]  Obesity (BMI >40) |
| [ ]  On immunosuppressant therapy  | [ ]  Malnutrition or low BMI (<17.5) | [ ]  Low white cell count | [ ]  Sickle cell | [ ]  Other (rare conditions like severe anaemia, mineral deficiency): |
| **Additional comments re health or circumstances e.g. mobility issues, medical equipment, care package in place or community psychiatric nurse or community nurse visits, please provide details:** |
|  |
| **Medications:** |
| Methadone / buprenorphine  | Dose prescribed:When was the last dose given:Has a prescription been given and / or doses given to take away:If yes, please include details: |
| **Medication list, or attach discharge summary** |  |
| **Does the client have 2 weeks medication:****(preferably in blister pack)** | [ ]  Yes [ ]  NoIf not, please specify:Amount:  | **Pharmacy details:** |
| **Last date of medication dispensing:**  |  | **Next dispensing date:** |
| **Any allergies:** | [ ]  Yes [ ]  No | If yes, provide details: |
| **Substance misuse and mental health:** |
|  | **Assessment**  | **Supports / main contact** |
| **ALCOHOL USE** [ ]  Yes [ ]  No-**Withdrawal risk? E.g. seizure, blackouts****- Alcohol management plan (alcohol type, how much/often)** |  |  |
| **DRUG USE**[ ]  Yes [ ]  No**- Drug type & method/poly?****- Drug management plan (how much/often?)** **- Risk of overdose?** **- Risk of benzo withdrawal?****- Prescriber informed of move?**  |  |  |
| **MENTAL/EMOTIONAL HEALTH**[ ]  Yes [ ]  No**-** **any** **self-harm** or **suicide ideation**, **current medication****- Consultant & community mental health nurse names** |  |  |
| **RISK TO/FROM OTHERS**[ ]  Yes [ ]  No**-violence/intimidation** |  |  |
| Any cognitive issues: | [ ]  Yes [ ]  No | **If yes, please provide details:** |
| **IF KNOWN: Where client originally came from – Street/Hostel/Shelter and geographical location**: |
|  |
| Interpreter needed: [ ]  Yes / [ ]  No Languages required: | Smoker: [ ]  Yes [ ]  No |
| **Next of kin information:** | Name/Contact details:Address:Phone Number:  |
| **Key worker / case worker details:** | Name:Organisation:Contact details: |
| Name:Organisation:Contact details: |
| **Any additional information:** |
|  |
| **Medical Officer Authorisation** |
| **Name:**  | **Designation:**  |
| **Signature:**  | **Date:**  |
| **UPON COMPLETION PLEASE EMAIL TO:** **hlp.hhc19hoteldischarge@nhs.net** |