**Transfer Document for people accepted into COVID Care from hotel or hostel**

To be used once an agreement has been made to transfer client to **COVID-CARE**

Send form with patient on transfer or electronically to haltteam.cnwl@nhs.net :

**Referring Site: ……………………………………………….…………………………………...**

**Local Authority contact (please provide details of commissioner where relevant and details of discussions about alternative accommodation options)**

**………………………………………………………………………………………………………………**

**Confirmation that hostel / hotel bed will remain available at discharge from COVID Care (please sign below)**

**…………………………………………………………………………………………………………………………………………………………………**

**Referrer contact name: …………………………………………………………………………………………………………………………..**

**Referrer contact email: …………………………………………………………………………………………………………………………..**

**Contact number: ……………………………………………………………………………………................................................**

**\*Patient name:........................................................................................................................................**

**\*DOB: ……………………………………………………………………………………...................\*Age: ….……………………………..**

**\*Phone** **number: ………………………………………………………………………………………**

|  |  |
| --- | --- |
| **GP Yes [ ]  No [ ]** **Permanent / temporary registration** | **Contact details**: Address: Contact no: |

**Known COVID +ve?**  Y/N **Date of test** ……………………………………………………………………………………………….

If YES, date symptoms began…………………………Currently symptomatic? Y/N

**Unknown COVID status**

Current COVID symptoms? Y/N If YES, date symptoms began…….

Awaiting test result? Y/N

If YES, did symptoms start more than 14 days ago? Y/N

**Medical and other vulnerabilities** Y/N

|  |  |
| --- | --- |
|  | Put X against all that you know of, with extra information if needed |
| >55  |  |
| Asthma  |  |
| COPD/bronchitis  |  |
| Chronic heart disease  |  |
| Diabetes  |  |
| Epilepsy  |  |
| Chronic kidney disease  |  |
| Chronic liver disease  |  |
| Chronic neurological disease (disease affecting brain or nervous system such as Parkinson’s)  |  |
| Splenic dysfunction  |  |
| Cancer  |  |
| HIV / AIDS or Weakened immune system due to other disease or treatment |  |
| Morbid obesity BMI>40  |  |
| Malnutrition or low BMI (<17.5) |  |
| Pregnant  |  |
| Sickle cell disease |  |
| Other physical condition |  |
| Mental health diagnosis |  |
| Cognitive impairment |  |
| Additional comments re health needs or circumstances, eg. mobility issues, medical equipment needed, care package in place  |  |
|  |  |

**Medication**

|  |  |
| --- | --- |
| **Methadone / buprenorphine**Dose prescribedWhen was the last dose given?Has a prescription been given and / or doses given to take away? Please include details **Name of drugs key worker and service****Name and contact details of pharmacy****Next dispensing date** |  |
| **Medication – please send any medication with the client and provide a list and where picked up from** |  |
| **Name of pharmacy** |
| **Any allergies (Y/N)** | **Details**:  |

**Substance misuse and mental health**

|  |  |  |
| --- | --- | --- |
|  | **Assessment** | **Supports / Main Contact** |
| **ALCOHOL USE**  Y N -**Withdrawal risk? eg. seizure, blackouts****- Alcohol management plan (alcohol type, how much/often)** |  |  |
| **DRUG USE**Y N **- Drug type & method/poly?****- Drug management plan (how much/often?)** **- Risk of overdose?** **- Risk of benzo withdrawal?****- Prescriber informed of move?**  |  |  |
| **MENTAL/EMOTIONAL HEALTH**Y X N -**any** **self-harm** or **suicide ideation**, **current medication****- Consultant & community mental health nurse names** |  |   |
| **RISK TO/FROM OTHERS**Y N **-Violence/intimidation** |  |   |

|  |
| --- |
| **Support Needs of Individuals** Can the individual self-contain with support in a hotel setting |
| Is the person exhibiting chaotic or uncontrolled behaviour due to unmanaged substance use or excessive alcohol use? | **Yes  No ** |
| Is the person at risk of exhibiting violent behaviour towards others?  | **Yes  No ** |
| Is the person unable to manage in a hotel with some support on site?  | **Yes  No ** |

Smoker: Y /N

Interpreter required? Y/N If YES, what language?...............................................................

|  |  |
| --- | --- |
| **Next of kin information:** **(Contact details?)****Are they aware of transfer?** | Name: Address:Contact Details: |
| **Key Worker /****Case Worker Details:** | Name: Organisation:Contact Details: |
| Name: Organisation:Contact Details: |

ANY OTHER KEY INFORMATION?...............................................................................................

**Transfer arrangements**

#### Transfer to COVID-CARE (symptomatic)

Public transport should not be used. Preferably book a Black cab. If travelling in a car or minibus with no partition between the driver and patient, both should wear a surgical mask and the windows should be left open for the duration of the journey.

Surface cleaning of passenger areas should be performed after transfer.