**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](mailto: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 prescribed  When 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.