**REFERRAL TO AGE UK BURY HOME FROM HOSPITAL SERVICE:**

**Telephone: 0161 778 3584: (83584)**

**Email:** [**homefromhospital@ageukbury.org.uk**](mailto:homefromhospital@ageukbury.org.uk)

**Eligibility Criteria for a Referral:**

* **Age 50+**
* **Lives alone or is Main Carer for another**
* **Pay Council Tax to Bury**
* **If Personal care is required, confirm the person has a home care package in place or a Carer at home**
* **Inpatient, or recently discharged from Fairfield General Hospital**

**Does the person meet the criteria detailed above? YES: NO:**

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| **Person’s Details:**  **Full Name:**  **Preferred First Name:**  **Address:**  **Postcode:**  **Home Contact Number:**  **Does the Person live alone? YES: NO:**  *(if no, detail who the person lives with)*  **Home Environment:** *(Please circle)*  Bungalow: Sheltered Housing:  House: Residential Facility:  Flat: Multiple Occupancy Building:  Extra Care Housing: | **Date of Birth:**  **NHS Number:**  **Key Safe Number:**  **Name of Next of Kin/Emergency Contact:**  **Relationship:**  **Contact Number:**  **Are there any access difficulties to the person’s home? YES: NO:** *(if yes, please detail)* |
| **Does the Person consent to you sharing their information (including health) to Age UK Bury? YES: NO:** | |
| **GP Details**:  Contact Number: | GP Surgery:  GP Address:  GP Email Contact: |
| If Referral has been sent from Hospital, please state ward: | Ward:  Ward Contact Number: |
| If Referral sent from Community, please state which team: | Community Team:  Community Contact Number: |
| Date of Referral: |  |
| Date of Hospital admission: |  |
| Reason for Admission: |  |
| Planned Discharge Date: |  |
| Reason for Referral to Home from Hospital Service: | |
| Has the person had a recent Covid 19 test? | YES: NO: Date of Test:  Result of Test: |
| **Please list any referrals that have been completed to other Community Teams:** | |
| **Other Services involved:**  Care Package: YES: NO: Number of Calls per Day:  Care Package Provider:  Family/Friend involvement: YES: NO: Name:  Contact Number: | |
| **Identified Support Needs relevant to the Home from Hospital Service:** *(please circle)* |  |
| Shopping support: YES: NO: | Housekeeping Support: YES: NO: |
| Community Meals: YES: NO: | Community Activities: YES: NO: |
| Welfare Visits: YES: NO: | Help to attend appointments: YES: NO: |
| Emotional Support: YES: NO: | Befriending Service: YES: NO: |
| Support with Benefit Checks: YES: NO: | Housing Issues: YES: NO: |
| Collection of Prescriptions: YES: NO: | Transport: YES: NO: |
| Attending Lunch Club: YES: NO: | Blue Badge: YES: NO: |
| **Does the person have any chronic health conditions?** |  |
| Stroke: YES: NO: | Arthritis: |
| Heart Disorder: YES: NO: | Chronic Obstructive Pulmonary Disease (COPD) YES: NO: |
| Visual Impairment: YES: NO: | Asthma: YES: NO: |
| Hearing Impairment: YES: NO: | Any Neurological Conditions: YES: NO: |
| Diabetes: YES: NO: | Dementia Diagnosis: YES: NO: |
| Mobility Issues: YES: NO:  (*If yes please provide details of mobility equipment used):* | Mental Health Condition: YES: NO:  *(If yes, please provide more details):* |
| **Does the person have any known Allergies or intolerances to Medications or Food groups: YES: NO:**  *(If yes, provide details):* | |
| **Are there any risk factors we need to be aware of?** |  |
| Self Neglect: YES: NO: | Hoarding: YES: NO: |
| Walking without purpose: YES: NO: | Falling: YES: NO: |
| Choking/Swallowing Risk: YES: NO: | Confusion/Memory Challenges: YES: NO: |
| **Does the person require a two person visit due to any of the following:** |  |
| Drug Dependency: | Alcohol Dependency: YES: NO: |
| Non-Engagement with staff: | Suicide Risk: YES: NO: |
| Aggression: | Behaviours that Challenge: YES: NO: |
|  |  |
| Does the person have Carelink? | Does the person have a warden? YES: NO: |
| **\*\*PLEASE CHECK THE REFERRAL FORM IS FULLY COMPLETED TO AVOID IT HAVING TO BE RETURNED: THANK YOU\*\*** | |