Saltstone Caring
Community Support Service

# Hospital Discharge
## REFERRAL FORM

*Jan 2013*

Date of Referral……..……. Hospital referring ……..

Name of referrer ……..…….. Position: …….

Tel ….…….. Email ……..……

Has patient consented to referral: Yes/No

Name of discharge patient …… Date of birth ……

Address ……

……. Postcode ……...…

Tel No …… Ethnic origin ……..

Disabilities/health issues …….

GP name …… Practice name ……..

Does client live alone? Yes / No If no, names of other occupiers of dwelling :

*Name ……..…….. Relationship……*
*Name ……..… Relationship ……..……*
*Why is volunteer requested if not sole resident……*

*Is client a smoker? Yes / No* *NB Saltstone Caring adopt the official NHS smoking policy with regard to outreach workers, whereby the client needs to refrain from smoking half an hour before our worker is due to arrive, and refrains from smoking whilst the worker is present.*

Emergency contact/next of kin ……..……. Tel ……..……

Does the hospital have any concerns …….

Has a care package been arranged? Yes / No

If yes name of provider …… Starting date …… Times …….

Day of discharge …… Time of arrival at home …….

If visit is needed **after** patient has arrived home time to visit is ……..

Background on health issues our visitor will need to be aware of
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Type of help needed: Companionship/shopping/mail/other ……..
*(if shopping, can list be obtained before hand (just basics for first visit?)*