**Integrated Care Network Referral Form**

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| **Patient referral criteria:**  **Please ensure patient meets referral criteria** | | **YES NO** |
| **Patient Details**  **Title: Name:**  **Address:**  **Tel No:**    **NHS No:**  **DOB:** | **GP Details**  **Name:**  **Surgery:**  **Address:**  **Tel No:**  **Hosp Consultant:** | |
| **Patient Consent for Referral**  **Yes ❑ No ❑**  **If no, do they have capacity or LPA?**  **Yes ❑ No ❑**  **Additional info:** | **NOK/Who to contact to make appointment**  **Name:**  **Telephone:**  **Relationship to patient:** | |
| **Main Diagnosis:** | **Medications:** | |
| **Reason For Referral (Please give some background history of the patient & why you want them to be referred to ICN):** | | |
| **Form completed by:**  **Email:**  **Date:** | **Designation:**  **Contact Number:** | |

**ICN Referral Criteria**

**Complete appropriate referrals as indicated. If patient has 3 or more of the above indicators also refer to Integrated Care Network (ICN)**

**If patient has a Rockwood of 6**

See below general indicators of poor or deteriorating health to be assessed alongside the Rockwood score:

* 3 or more unplanned hospital admissions in last 6 months? Consider referral to ICN
* Recent unexplained weight loss? – consider referral to GP for bloods and consider referral to dietician
* New falls risk/Poor mobility? – consider referral to Physio Falls or RATT
* New change in cognitive status? – Complete AMTS, NEWS2, Consider referral to GP
* Evidence of delirium? – Consider referral to Rapid Response
* New or deterioration in continence status? – Consider referral to Bladder & Bowel
* Long term condition requiring symptom control – Consider referral to Community Matrons or specialist team (e.g. Respiratory/Diabetes)
* Poor medication compliance – Consider referral to MOSS or GP
* Increased or new difficulties with activities of daily living – Consider referral to Occupational Therapy
* New swallow difficulties – Consider referral to Speech and Language Team (SALT)
* If the patient has a package of care does it meet their need? If not – Consider referral to Social Services/Care Manager
* New Safeguarding / Self Neglect noted – Consider referral to Adult Safeguarding
* 3 or more long term conditions – Consider referral to Community Matrons

**If patient has a Rockwood of 7**

See below general indicators of poor or deteriorating health to be assessed alongside the Rockwood score,

* 2 or more unplanned hospital admissions in last 2 months? Consider referral to ICN
* Recent unexplained weight loss? – consider referral to GP for bloods and consider referral to dietician
* New falls risk/Poor mobility? – consider referral to Physio or RATT
* New change in cognitive status? – Complete AMTS, NEWS2, Consider referral to GP
* Evidence of delirium? – Consider referral to Rapid Response
* New or deterioration in continence status? – Consider referral to Bladder & Bowel
* Long term condition requiring symptom control – Consider referral to Community Matrons or specialist team (e.g. Respiratory/Diabetes)
* Poor medication compliance – Consider referral to MOSS or GP
* Increased or new difficulties with activities of daily living – Consider referral to Occupational Therapy
* New swallow difficulties – Consider referral to Speech and Language Team (SALT)
* If the patient has a package of care does it meet their need? If not – Consider referral to Social Services/Care Manager
* New Safeguarding / Self Neglect noted – Consider referral to Adult Safeguarding
* 3 or more long term conditions – Consider referral to Community Matrons

**Complete appropriate referrals as indicated and refer patient to Integrated care Network (ICN) if patient has 3 or more long term conditions and / or 2 unplanned admissions in the past 2 months**

***In addition for community nursing - Ensure patient is discussed at multi professional Gold Standard Framework meetings and entered on to CMC by GP or St Christopher’s Hospice Specialist Nurse and consider referral to BCC with patients consent.***

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**If patient has a Rockwood of 8 and above**

Ensure Senior Community Nurse reassessment has taken place or scheduled on Malinko. Sr Nurse to consider advance care planning (ACP) conversations with patient to ensure patient’s preferences known and recorded. Consider DNACPR. Consider care planning for advice and support and symptom control.

Consider St Christopher’s BCC referral and input by Community nurse specialists if appropriate

In addition for community nursing - Ensure patient is discussed at multi professional Gold Standard Framework meetings and entered on to UCP by GP or St Christopher’s Hospice Specialist Nurse