Ceredigion Porth Gofal MDT Request for Help

To be completed for all routine referrals. For urgent referrals please call the MDT Triage Team on 01545 574000

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| **Patient Details: (Or Addressograph)** |
| Hospital / NHS number:WCCIS:Full Name:Date of Birth:Address: | Preferred Name:Title: Mr / Mrs / Ms / Miss / Dr / Other:Sex:Marital status: |
| First language:Preferred language: |
| Next of Kin Name:Relationship to Person:Tel: |
| Home tel number:Alternative number: | GP:Surgery: |
| **CONSENT: YES proceed to next questions****Does the person consent to a referral being made to Porth Gofal Health & Social Care Service?** **Has the ‘What Matters to You’ conversation taken place with the person?** |
| **Are there any concerns with Mental Capacity? YES / NO** **Any concerns with memory or cognitive function? YES / NO** |  **If YES please contact Porth Gofal on** **01545 574000**  |
| **Is this a request for Occupational Therapy Pre Operative / Site Access Assessment? (Please indicate which)** **Estimated Date of Admission / Discharge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Is this a request for review of individual(s) previously known to Long Term Social Care Team?**  |
| Why does the person need support? What do they need support with? |
| History of Presenting Condition / Recent hospital admissions related to this problem (with dates): |
| **General Health: Any physical or mental health problems?** |
| **Medical Problems:** | **Y/N** |  | **Y/N** | **Details / Other:** |
| Thyroid |  | Dementia/Memory problems |  |
| Heart condition  |  | Depression / anxiety /Mood |  |
| Respiratory condition |  | Cancer |  |
| Epilepsy |  | Fractures / Osteoporosis |  |
| Arthritis (OA / RA) |  | Neurological condition |  |
| Diabetes |  | Falls |  |
| Blood Pressure |  | Alcohol/ drug use  |  |
| Unexplained Weight Loss |  | Smoking |  |
| Stroke / TIA |  | Continence problems |  |
| **Current medication** | **Medication Management** |
| Medication / Dose / Frequency | Independent |  |
| Dosette box |  |
| Blister pack |  |
| MAR chart / carers  |  |
| Family support |  |
| How will prescriptions be collected? |
| **Risk Assessment:** |
| **Medication risk****Eg allergies, reaction, accessing meds, swallow** |  | **Environmental risks****Eg Pets, fire, isolated property, phone, access** |  |
| **Manual handling risk:****If YES All Wales Manual handling or therapeutic handling risk assessment to be sent to PG** | YES / NO | **Wellbeing issues****Eg Appetite, mood, swallow, tissue viability, diet**  |  |
| **Falls risk****Any previous falls?****Environment, hazards** |  | **Communication** **Hearing, visual impairment, speech, telephone use** |  |
| **Night time risk****Continence over night****Mobility / Transfers** |  | **Lone working risk****Any risk to staff** |  |
| **Location / Support:** |
| Lives alone? Y/NResides with: | Formal / informal carer /Family / local support network?  | Telecare Y/NRef made? Date: | Pendant alarm? Y/NRef made? Date: |
| Namefamily / carer / formal / informal / friend / otherTelephoneNamefamily / carer / formal / informal / friend / otherTelephone | Able to answer the door? Y/N Access via: front door / back door / other |
| Key Safe Y/N (please do not include key safe code on this ref form – contact PG) |
| **Type of property**  | **Tick** | **Equipment in property?** | **Property** | **Heating** |
| House |  | Bed lever / bed aids |  | Stairs Internal / external | 1 rail L / R2 rails Stair lift | Is person able to manage heating? Y/NHeating type:Central heating - gas / oil / electricStorage heatersElectric / gas / coal fireOther? |
| Flat |  | Raised toilet seat / Mobray |  |
| Bungalow |  | Commode/wheeled commode |  |
| Other: | Bath / shower aids |  |
| Chair / bed raisers  |  | Toilet | UpstairsDownstairs |
| Grab rails |  |
| Access:Front door / Back door / Steps / Stairs /Ramp / Handrails | Perching stool |  | Bed | Upstairs Downstairs |
| Riser recliner chair |  |
| Walking aid |  | Bath / Shower | Upstairs Downstairs |
| Wheelchair |  |
| Other: |  |
| Activities:Functional Mobility: What can the person do? | Current functional mobilityIndependent / Assistance / Supervision / with equipment or aid | Previous functional mobility |
| Lying to sitting |  |  |
| In and out of bed |  |  |
| In and out of Chair |  |  |
| On / off toilet |  |  |
| Walking |  |  |
| Stairs / Steps indoors |  |  |
| In / out bath or shower |  |  |
| **Functional Ability** | **Current functional ability** | **Previous functional ability** |
| Use toilet |  |  |
| Wash upper body |  |  |
| Wash lower body |  |  |
| Dress upper body |  |  |
| Dress lower body |  |  |
| Prepare hot drink |  |  |
| Meals |  |  |
| Shopping |  |  |
| Laundry / Housework |  |  |
| **Escalation: Is person already known to Health or Social Care Services? YES / NO** |
| **Professionals / agencies involved**  | **Known previous involvement / rehabilitation** | **Long term management or personal care plan in place** |
| Enablement / GP /District nurse / SALT / Social worker / Podiatrist /Practice nurse / Physiotherapist / Occupational Therapist/Dietician / Third sector /Specialist nurse: Other:Not known |  | Is person for Resuscitation Y/NDNACPR in place Y/NAdvance Decisions Y/NPower of Attorney:Health Y/NFinance Y/NLong term conditions management plan NOK:Tel: |
| **Undergoing investigations (DGH/Consultant)** |
|  |
| **Current support / MDT involvement: name / contact** | Social worker: |
| Occupational Therapy: | Third sector: |
| Physiotherapy: | Formal / informal carer: |
| Nursing: | Other support: |
| Summary of What Matters to You Conversation: |
| Clinical judgement of the person’s needs and short term support required: |
| Enablement Please complete below to support reasoning | Adult Social Care | Occupational Therapy | Community Physiotherapy |
| **Enablement Service Request for Help:**  |
| **Calls required**  | **Details of reasoning for request / Goal(s) to be achieved** |
| **Morning** |  |  |
| **Lunchtime** |  |  |
| **Teatime** |  |  |
| **Evening** |  |  |
| **Days required** | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name** |  | **Designation** |  |
| **Location**  |  | **Contact number** |  |
| **Signature** |  | **Date / Time of Referral** |  |

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| For Office Use. If Urgent /completed by PG: |
| Signature  |  | Designation |  | Date / Time of Referral |  |
| ANGEL Taxonomy Individual #MyScore |
| Activities | Needs | Goals | Escalation | Location | Total |
|  |  |  |  |  |  |

**Please fax completed form to Porth Gofal: 01545 574002 or email:** **contactsocservs@ceredigion.gov.uk**

***This form is also available in Welsh***