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/N  Resides with: | | | | Formal / informal carer /  Family / local support network? | | | | | | | | | Telecare Y/N  Ref made? Date: | | | | | | Pendant alarm? Y/N  Ref made? Date: | | | | | |
| Name  family / carer / formal / informal / friend / other  Telephone  Name  family / carer / formal / informal / friend / other  Telephone | | | | | | | | | | | | | 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 / R  2 rails  Stair lift | | | | | | Is person able to manage heating? Y/N  Heating type:  Central heating - gas / oil / electric  Storage heaters  Electric / gas / coal fire  Other? | | |
| Flat | |  | | Raised toilet seat / Mobray | | | | | |  | | |
| Bungalow | |  | | Commode/wheeled commode | | | | | |  | | |
| Other: | | | | Bath / shower aids | | | | | |  | | |
| Chair / bed raisers | | | | | |  | | | Toilet | | | Upstairs  Downstairs | | | | | |
| 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 mobility  Independent / 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/N  DNACPR in place Y/N  Advance Decisions Y/N  Power of Attorney:  Health Y/N  Finance Y/N  Long 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**](mailto:contactsocservs@ceredigion.gov.uk)

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