**Referrals will be processed during our hours: Mon – Thurs 08:00 – 16:30, Fri 08:00 – 13:00. Referrals received outside these hours are processed the next working day. Please see details on TRAK for any declined referrals**.

**District Nursing Service Referral Form**

Refer to East Lothian: [loth.eldnteams@nhs.scot](mailto:loth.eldnteams@nhs.scot) | Edinburgh: [loth.edinburghdnteams@nhs.scot](mailto:loth.edinburghdnteams@nhs.scot)

Midlothian: [loth.mldnteams@nhs.scot](mailto:loth.mldnteams@nhs.scot) | West Lothian: [loth.wldnteamleads@nhs.scot](mailto:loth.wldnteamleads@nhs.scot)

**For end of life or emergency visits and on public holidays, please contact your district nursing team directly**.

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| **SECTION 1 – Referrer Information and Patient Details**  Please note, section 1 is a mandatory section, if the form is submitted without completion of section 1 it will not be processed. | | | | |
| Patient status: | Choose an item. |  | **Please note, if the patient is not housebound the case should be referred to the local CTAC or practice nurse.** | |
| Date of referral: | Click or tap to enter a date. |  | Time of referral: | Choose an item. |
| Name and job title of referrer: | Click or tap here to enter text. |  | Name of GP: | Click or tap here to enter text. |
| Location: eg. Hospital Ward / GP Practice | Click or tap here to enter text. |  | Contact number of referrer: | Click or tap here to enter text. |

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| Full patient name: | Click or tap here to enter text. |  | Is the patient known to the district nursing team | Choose an item. |
| Patient date of birth: | Click or tap here to enter text. |  | Patient CHI: | Click or tap here to enter text. |
| Patient home address: | Click or tap here to enter text. |  | Discharge address (if different) | Click or tap here to enter text. |
| Phone number for home address: | Click or tap here to enter text. |  | Phone number for discharge address: | Click or tap here to enter text. |
| Name and relationship of next of kin: | Click or tap here to enter text. |  | Phone number of next of kin: | Click or tap here to enter text. |
| Date of planned discharge: | Click or tap to enter a date. |  | Referral type: | Choose an item. |
| Concerns  (select all that apply) | Access:  Infection Control:  Safeguarding:  Lone working: |  | Note details of concerns: | Click or tap here to enter text. |

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| **SECTION 2 – Diagnosis and Reason for Referral**  Please only complete sections that are relevant to the patient. | | | | |
| **Wound Care / Skin Tear**  **Please supply dressings for 7 changes with clip remover is appropriate for the patient.** | | | | |
| Reason for wound / skin tear: | Click or tap here to enter text. |  | Date of last dressing: | Click or tap to enter a date. |
| Site of wound / tear: | Click or tap here to enter text. |  | If the wound is packed, how many dressings are being used? | Click or tap here to enter text. |
| Dressings / Topical Apps being used: | Click or tap here to enter text. |  | Drain status: | Choose an item. |
| If a drain is in situ, does it need changing: | Choose an item. |  | Are spares provided? | Choose an item. |

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| **Pressure Ulcers or Pressure Damage**  **If the wound was acquired in hospital, please complete a DATIX report prior to discharge.** | | | | |
| Grade of ulcer: | Choose an item. |  | Is adequate pressure-relieving equipment in place within the home? | Choose an item. |
| Site of ulcer: | Click or tap here to enter text. |  | If answer to the above is no, please provide details: | Click or tap here to enter text. |
| Date of last dressing: | Click or tap to enter a date. |  | Has a DATIX report been completed? | Choose an item. |

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| **Injections – Including Insulin**  **Please complete and attach the drug administration sheet if appropriate for the patient.** | | | | |
| Drug and dose: | Click or tap here to enter text. |  | Is a supply of drugs with the patient? | Choose an item. |
| Date and time for first injection: | Click or tap here to enter text. |  | Will the patient receive an injection prior to discharge? | Choose an item. |
| Start date: | Click or tap to enter a date. |  | Is self-care / carer administration achievable? | Choose an item. |
| Stop date: | Click or tap to enter a date. |  | If no, who normally administers injections to the patient? | Click or tap here to enter text. |
| What items have been supplied to the patient?  (select all that apply) | Sharps Bin:  Needles:  Green Book:  Monitor: |

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| **Urinary Catheters / Continence:** | | | | |
| Catheter placement: | Choose an item. |  | Date of last change: | Click or tap to enter a date. |
| Catheter type: | Choose an item. |  | Date next change due: | Click or tap to enter a date. |
| Catheter size: | Click or tap here to enter text. |  | Has a catheter passport been issued? | Choose an item. |
| Reason for catheter insertion: | Click or tap here to enter text. |  | Has the patient been referred for further supplies? | Choose an item. |
| Date continence assessment completed: | Click or tap to enter a date. |  | Has the patient been referred to the Bowel and Bladder team? | Choose an item. |

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| **Single Episode**  **Please note bloods will only be undertaken if the patient is being visited by a District Nurse for another nursing need.** | | | | |
| Service Need  (select all that apply) | Removal of Sutures:  Removal of Clips:  Bloods: |  | Does the patient have a bloods form: | Choose an item. |
| Additional Service Need Details: | Click or tap here to enter text. |

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| **Palliative Care** | | | | |
| Is the patient and family aware of the diagnosis & prognosis: | Choose an item. |  | Are medications and prescription chart for the syringe driver with the patient: | Choose an item. |
| Does the patient have a syringe driver in situ: | Choose an item. |  | Is the DNACPR form completed: | Choose an item. |
| If yes to above, note the date of next change | Click or tap to enter a date. |  | Is the DNACPR form with the patient: | Choose an item. |
| If yes to above, note time of the next change | Click or tap here to enter text. |  | Have any of the following referrals been made (select all that apply) | Marie Curie:  Hospice at Home:  Hospital at Home:  Package of Care: |
| Note any additional relevant information: | Click or tap here to enter text. |  | Note details of referrals: | Click or tap here to enter text. |

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| **Additional Information**  (e.g. Is the patient known by any other health professional?) |
| Click or tap here to enter text. |