

EVOLVE Care Group District Nursing Referral Form - Coded System – Communication Template

Name of the Person	
DOB	
Gender	
DOA	
NHS Number	
GP – Name and Address	
Name and Address of Nursing Home [inc. telephone number, email address]	

Referrals made or involvement from other services – shade as appropriate and date							
GP	Tissue Viability	Lower Limb [inc podiatry]	Wet Leg Team	SALT	Falls Team	Dietician	Bladder & Bowel
Urology	Memory Clinic	Mental Health	Diabetes	Parkinsons Team	Any other specialist services:		

Referrer Check List – Add YES and DATE to appropriate referral pathway	
New Admission to Nursing Home Residential Funded – GREEN ALERT <i>Complete on residential admissions – no active District Nursing input identified</i>	
Change in Physical Presentation – AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Change in Mental Health Presentation – AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Dual Change [Physical and Mental Health] - AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Active Clinical Oversight Required Ongoing – RED Alert – <i>Urgent review</i> <i>District Nursing visit required and leadership of active health issues identified</i>	
Multiple Areas of Clinical Oversight Required Ongoing – PURPLE Alert <i>Urgent review</i> <i>Multiple areas of nursing needs identified. CHC / FNC application required and change of contract required by the Provider.</i> <i>Part 2 to be completed</i>	

Medical History:	
Medication Prescribed: [inc. PRN prescriptions] -	
Amy medication requested by the GP:	Last Acute Admission:

Reasons for Referral							
For Green Referrals Detail Potential Risk that require Health Input into the Social Care plan – shade as appropriate							
MUST		Waterlow		Falls		Diabetes	
COPD							
Other Risks:							
For Amber, Red or Purple Referrals complete the following [shade as appropriate]							
Catheter in place	Ostomy in place	PEG in place	MUST Score >	Waterlow Score >	Falls Risk >	PRN Medication that requires Clinical Oversight owing to increase in risk [add detail below]	
Pressure Damage G1	Pressure Damage G2	Pressure Damage G3	Pressure Damage G4 +	SDTI	Skin Tears/Lacerations/Hematoma	Leg Ulcers	Constipation Concerns
DVT Risk – Active	Blood Pressure Concerns –active nursing oversight	Bilateral leg oedema	Diabetes – unstable and/or complex	COPD active nursing oversight required	Epilepsy	Any other areas where Nursing Oversight is required:	
Any other detail/reason for referral/explanation of the above [Amber, Red or Purple Referrals]							
Care Plans/Risk Assessments required to be written by a District Nurse Amber, Red or Purple Referrals : [detail below]							
Baseline Information							
NEWS Score [add detail]			Scale 2 Sign Off [range and date]			Baseline PAINAD [add detail]	
MUST Score	=	BMI Score	=	Waterlow Score	=		
DNACPR in place			Yes			No	
For Hospital Admission [as per TEP or ACP]			Yes			Maybe for symptom control No	

Does the person have capacity?	
If yes, are they aware the referral has been made?	
Date the GP last contacted	
NOK Details	
Referrer [Full name]	
Designation	
Date Referral sent to the DN Team	