| **Homeless Health COVID-19**  **Referral form for Hospital Discharge – Acute Care**  **(including inpatients, emergency department and mental health wards)** | | | | | | NHS Patient Identifying Number (if known):  Family name:  Given name(s):  Phone number:  Current address/known address (if avail.):  Date of birth: Sex:  M  F  I | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Referring Hospital:** | | | | | | | | | | **Referrer contact details:** | | | |
| This information is confidential and is provided for medical purposes | | | | | | | | | | | | | | |
| TRANSFER TO:   1. **COVID-CARE** – (symptomatic or positive, or less than 14 days since onset of illness) 2. **COVID-PROTECT** – (vulnerable but COVID negative / asymptomatic – no symptoms in last 14 days)   Send form to: **hlp.hhc19hoteldischarge@nhs.net**  Placement in the hotels is a last resort and a short-term measure.  You should also make a **duty to refer** for anyone who is homeless or threatened with homelessness. Always contact your discharge coordinator and pursue normal housing channels as well.  **Please discuss rules of self-isolation with the patient** | | | | | | | | | | | | | | |
| **Original reason for admission:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Brief discharge summary with key conditions and ongoing care needs (cut and paste as necessary):** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Registered General Practitioner** | | | | | | | | | | | | | | |
| Yes  No | | | | Name/Contact details:  Address:  Phone Number: | | | | | | | | | | |
| **Known COVID + ve** | | | | | | | | | | | | | | |
| Yes  No | | | | If yes, date symptoms began:  Currently symptomatic:  Yes  No | | | | | | | | | | |
| **Unknown COVID Status** | | | | | | | | | | | | | | |
| Current COVID symptoms: | | | | Yes  No | | | | | If yes, date symptoms began:  Awaiting test result: | | | | | |
| Were they admitted with symptoms: | | | | Yes  No | | | | | If yes, did symptoms start more than 14 days ago: | | | | | |
| **Medical and other vulnerabilities:** | | | | | | | | | | | | | | |
| >55 | | Pregnant | | | Asthma | | | | | COPD/bronchitis | | | | Chronic Heart Disease |
| Diabetes | | Epilepsy | | | Chronic Kidney Disease | | | | | Chronic Liver Disease | | | | Chronic Neurological Disease (PD/MND/LD etc) |
| Splenic Dysfunction/removal | | HIV/AIDS | | | Cancer Treatment | | | | | Weakened Immune system | | | | Obesity (BMI >40) |
| On immunosuppressant therapy | | Malnutrition or low BMI (<17.5) | | | Low white cell count | | | | | Sickle cell | | | | Other (rare conditions like severe anaemia, mineral deficiency): |
| **Additional comments re health or circumstances e.g. mobility issues, medical equipment, care package in place or community psychiatric nurse or community nurse visits, please provide details:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Medications:** | | | | | | | | | | | | | | |
| Methadone / buprenorphine | | | Dose prescribed:  When was the last dose given:  Has a prescription been given and / or doses given to take away:  If yes, please include details: | | | | | | | | | | | |
| **Medication list, or attach discharge summary** | | |  | | | | | | | | | | | |
| **Does the client have 2 weeks medication:**  **(preferably in blister pack)** | | | Yes  No  If not, please specify:  Amount: | | | | | | | | | | **Pharmacy details:** | |
| **Last date of medication dispensing:** | | |  | | | | | | | | | | **Next dispensing date:** | |
| **Any allergies:** | | | Yes  No | | | | | | | | | | If yes, provide details: | |
| **Substance misuse and mental health:** | | | | | | | | | | | | | | |
|  | | | **Assessment** | | | | | | | | | **Supports / main contact** | | |
| **ALCOHOL USE**  Yes  No  -**Withdrawal risk? E.g. seizure, blackouts**  **- Alcohol management plan (alcohol type, how much/often)** | | |  | | | | | | | | |  | | |
| **DRUG USE**  Yes  No  **- Drug type & method/poly?**  **- Drug management plan (how much/often?)**  **- Risk of overdose?**  **- Risk of benzo withdrawal?**  **- Prescriber informed of move?** | | |  | | | | | | | | |  | | |
| **MENTAL/EMOTIONAL HEALTH**  Yes  No  **-** **any** **self-harm** or **suicide ideation**, **current medication**  **- Consultant & community mental health nurse names** | | |  | | | | | | | | |  | | |
| **RISK TO/FROM OTHERS**  Yes  No  **-violence/intimidation** | | |  | | | | | | | | |  | | |
| Any cognitive issues: | | | Yes  No | | | | | | | | | **If yes, please provide details:** | | |
| **IF KNOWN: Where client originally came from – Street/Hostel/Shelter and geographical location**: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Interpreter needed:  Yes /  No  Languages required: | | | | | | | Smoker:  Yes  No | | | | | | | |
| **Next of kin information:** | | | | | | | Name/Contact details:  Address:  Phone Number: | | | | | | | |
| **Key worker / case worker details:** | | | | | | | Name:  Organisation:  Contact details: | | | | | | | |
| Name:  Organisation:  Contact details: | | | | | | | |
| **Any additional information:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Medical Officer Authorisation** | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | **Designation:** | | | | | | |
| **Signature:** | | | | | | | | **Date:** | | | | | | |
| **UPON COMPLETION PLEASE EMAIL TO:** [**hlp.hhc19hoteldischarge@nhs.net**](mailto:hlp.hhc19hoteldischarge@nhs.net) | | | | | | | | | | | | | | |