Healthy London Partnership

Homeless Health COVID-19

Symptomatic referral for testing: Hotel or Hostel

NHS Patient Identifying Number (if known):

Family name:

Given name(s):

Phone number:

Current hotel or hostel name and address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date:	**Referrer Name:**	**Referrer contact detail:**

This information is confidential and is provided for medical purposes

Accommodation		**Symptoms on admission**	
Own room with own bathroom	☐	Fever	☐
Own room sharing bathroom with less than 5 others	☐	Cough	☐
Own room sharing bathroom with 5 or more others	☐	Shortness of Breath	☐
Shared room with less than five others	☐	Chest pain	☐
Shared room with 5 -19 others	☐	Muscle ache	☐
Shared room with 20 or more others	☐	Joint pain	☐
		Fatigue	☐
		Confusion	☐
		Nausea/Vomiting	☐
		Loss of sense of smell or taste	☐
		Sore Throat	☐

Date of onset of symptoms: __/__/__

Current medications if known:

Vulnerabilities: Tick any that apply that you know of:

☐ age over 55	☐ Pregnant	☐ Asthma	☐ COPD/bronchitis	☐ Chronic Heart Disease
☐ Diabetes	☐ Epilepsy	☐ Chronic Kidney Disease	☐ Chronic Liver Disease	☐ Chronic Neurological Disease
☐ Splenic Dysfunction/removal	☐ HIV/AIDS	☐ Cancer Treatment	☐ Weakened Immune system	☐ Obesity (BMI >40)

Languages spoken:
Interpreter needed: ☐ Yes / ☐ No

MH/Addictions:

Any additional behavioural risks, if yes please provide details:

Is the person exhibiting chaotic or uncontrolled behaviour due to unmanaged substance use or excessive alcohol use, at risk of violent behaviour, very high support needs?

UPON COMPLETION PLEASE EMAIL TO: haltteam.cnwl@nhs.net (referrals triaged daily and will be followed up by a phone call)