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| **Singe Point of Contact (SPOC) Referral Form** | |
| **Personal Details** | |
| NHS Number: | Date of birth: |
| Title: | First Name: |
| Surname: | Known as: |
| Address: | |
| Post Code: | Telephone: |
| GP (if not referrer): | Surgery: |
| Nationality/Language: | Ethnic Origin: |
| Gender: | Religion: |
| **Next of Kin** | |
| Name: | Relationship: |
| Address: | |
| Post Code: | Telephone: |
| Does the patient have a keysafe/are there any access issues at the patient’s residence?  Please provide the contact details of a person who can confirm the keysafe number.  **Please DO NOT write the keysafe number on this form** | |
| When all sections are completed, please forward using electronic referral via SystmOne or  email to [hnf-tr.csspoc@nhs.net](mailto:hnf-tr.csspoc@nhs.net) | |
| **Referrer Information** | |
| Referrer name: | Occupation: |
| Organisation: Date: | Telephone: |
| **Intervention required** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Cardiac Rehab |  | Heart Failure |  | Respiratory Nursing | |  | Urgent Community Response (Crisis) |  | Home Oxygen (see HOS-AR form) |  | Respiratory Physiotherapy | |  | Continence Service |  | MSK Physio Outpatients |  | Speech and Language Therapy | |  | Diabetes |  | Occupational Therapy |  | Stroke Services | |  | Dietetics |  | Physiotherapy - Community |  | Tissue Viability | |  | District Nursing |  | Pulmonary Rehabilitation |  | Intermediate Care | |  | Pharmacy |  | COVID-19 Swab Testing |  | Elderly Medicine | |  | Virtual Ward - **Please ensure the patient meets the criteria for Virtual Ward.**  **When selecting Virtual Ward, no other service should be selected.** | | | | |   Is this referral Urgent Routine | |
| Is a Frailty Assessment required? Yes / No. If yes:  Rockwood Score: | |
| Reason for referral (include relevant previous medical history): | |
| Can this patient be seen in a clinic? Yes / No | |
| Has the patient consented to this referral?  Yes  No | |
| Other relevant clinical / patient information (**including lone worker safety considerations**): | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Home Oxygen Service Assessment and Review (HOS-AR) Referral Form  Scarborough, Ryedale and Whitby**  **(Please also see referral pathway for guidance)** | | | | | | |
| **MEDICAL HISTORY** | | | | | | |
| Diagnosis: |  | | | | | |
| Resting SpO2 on Air: |  | | Last exacerbation date: | | |  |
| Spirometry (date): | FEV¹ | | FEV¹ % | | | FVC |
| Completed and reviewed within 3 months of referral: | CXR | | ECG / ECHO | | | FBC |
| Is patient fully optimised? | Yes / No | | | | | |
| **OXYGEN REQUESTED (please select)** | | | | | | |
| Long Term Oxygen Therapy     * Resting SpO2 ≤ 92% on 2 occasions or * ≤ 94% Polycythaemia/Pulmonary HTN | | Ambulatory Oxygen Therapy     * Evidence of exercise desaturation   ( SpO2 <90% *or* SpO2 drop >4% )   * Require oxygen outside of the home | | Palliative Oxygen Therapy     * Symptomatic patient with SpO2 92%< | | |
| Exclusion Criteria:   * Current smokers *(Please refer to smoking cessation, reconsideration for oxygen when 3/12 smoke free)* * Patients condition not fully optimised *(please consider appropriate referral to Pulmonary Rehabilitation)* | | | | | | |
| **COMMUNITY DIABETES REFERRAL FOR**  **SCARBOROUGH AND RYEDALE**  **(Please also see referral pathway for guidance)**  **ALL PATIENTS NEED TO BE CONSIDERED FOR GROUP EDUCATION PRIOR TO REFERRAL FOR ONE:ONE SPECIALIST CARE** | | | | | | |
| **MEDICAL HISTORY** | | | | | | |
| Diagnosis: | Type 1 Diabetes  Type 2 Diabetes  Secondary disease  Details ( EG. Pancreatitis) | | | | | |
| Medications | Oral Meds | | Insulin | | Other meds | |
|  |  | |  | |  | |
|  |  | |  | |  | |
| Relevant history | Alcohol Abuse | | Drug Abuse | | Is patient fully optimised in oral medication pathway?  Yes  Contraindicated | |
|  | | | | | | |
| Blood tests  HBa1c  U&Es  LFTS  Cholesterol  Renal concerns  E.g. AKI or high stage of CKD | | Libre Flash Glucose Monitoring (Community Criteria)  Has routinely required eight or more blood glucose tests per day as recommended by the Specialist Diabetes Team  🞏 Has routinely required eight or more blood glucose tests per day as recommended by the Specialist Diabetes Team  🞏 Unable to routinely self-monitor blood glucose due to disability and requires carers to support glucose monitoring and insulin management.  🞏 Occupational or psychosocial circumstances that warrant a six month trial of FreeStyle Libre.  🞏 Recurrent severe hypoglycaemia or impaired awareness where a trial of FreeStyle Libre® is more appropriate for the individual’s specific situation.  🞏 Two or more admissions with diabetic ketoacidosis in the last 12 months.  🞏 Has diabetes associated with cystic fibrosis and is on insulin therapy. | | EDUCATION STRUCTURED    TYPE 1- DAFNE  TYPE2- STRUCTURED EDUCATION  (Need up to date HBa1c and Cholesterol) | | |
| Exclusion Criteria:  Pregnant patients, insulin pump patients, Renal dialysis patient.  (If in doubt check the criteria pathway) or speak with the DSN TEAM Via SPOC. | | | | | | |

***NB: Please ensure referrals are completed fully with all the required information or it may be rejected.***