**WCH Rapid Assessment Frailty Referral Form**

**Patients Name:**

**Address:**

**DOB:**

**NHS / Hospital no:**

|  |
| --- |
| Clinician Responsible for referral: Contact details:Patients own GP: Patient own GP Approves of Referral (√ if yes) |
| S | **Acute change / problem** |  |
| **TEP in place**: **Yes/No** Patient and NOK:  **Yes/No**  |
| **Ceiling of care:**Patient and NOK discussion:  **Yes/No**  |
|  | **Continence** | **Confusion** | **Mobility** | **ADL** |
| **1** | Fully continent | No confusion | Independent with mobility >200 yards | Nil |
| **2** | Occasionally incontinent urine | Mild confusion | Mobile with stick (safe) | ShoppingCleaning |
| **3** | Regularly incontinent urine | Moderate confusion | Mobile Furniture walk – 10 yards | 1 call / care |
| **4** | Occasionally faecal incontinence | High confusion | Mobile with frame | 2 calls / care |
| **5** | Doubly incontinent | Severe confusion | Mobile with 1 | 4 calls / care |
| **Total Score =** |  |  | Mobile with 2 | Double handed 4 x per day |
|  |  | Immobile / bed bound |  |
| **A** | **B** | **C** | **D** |
| B | **Significant medical history** |  |
| **Social circumstances including support in place and person’s wishes** |  |
| **Medications including allergies** |  |
| A | **Assessment aims/goal** |  |
| **What needs to be in place for safe return to home** |  |
| **Clinician Responsible at home**  | Name:Phone: | Next of Kin Informed: **Yes/No** **Name:****Phone:** |
| R | **Appointment time** |  |
| **Transport needs** | Own transport: :**Yes/No** Wheelchair Taxi arranged: **Yes/No** |
| D | **Rapid Assessment Frailty clinic outcome** |  |
| FORM TO BE USED AS AN AID TO THE TELEPHONE REFERRAL: IT DOES NOT HAVE TO BE SENT TO WCH TEAM |

**Referral Date:**

**Time:**