COVID-19 Early Supported Discharge and Community Rehabilitation

Transfer of Care Form V6  
*Guidance Notes: Please complete this summary transfer of care document for referrals to Early Supported Discharge, Intermediate Care, Community Rehabilitation or Review Services only. This document is designed to be completed electronically but can be completed by hand and scanned to be sent electronically. Electronic referrals must be sent via a secure email such as NHSMail.*

[*barnsleycommunitystroketeam@nhs.net*](mailto:barnsleycommunitystroketeam@nhs.net)

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| **SECTION 1: PERSONAL DETAILS:** | | |  | | | |
| Full Name: | | | NHS Number: | | | |
| Date of Birth: | | | Next of Kin: | | | |
| Address: | | | Preferred Contact Number: | | | |
| Ethnicity: | | | Religion: | | | |
| Date of Current Admission: | | | Date of Transfer/Discharge: | | | |
| **SECTION 2: GP DETAILS:** | | |  | | | |
| Address including postcode: | | | Telephone no: | | | |
| **SECTION 3: REFERRAL DETAILS:** | | | | | | |
| Referring Organisation: STH / DBTH / MYT / BHFT / RHFT / SWYFT *\*delete as applicable* | | | | | | |
| Name of Consultant/referrer: | | | | | | |
| Has patient consent been gained for the referral? YES / NO*\*delete as applicable* | | | | | | |
| Does the patient have capacity to consent? YES / NO*\*delete as applicable* | | | | | | |
| If the person does not have capacity, was the decision made in a best interest meeting? YES / NO | | | | | | |
| If no, give details: | | | | | | |
| DNACPR in place: YES /NO Date of issue: Review date: ReSPECT Documentation in place: YES / NO | | | | | | |
| Has the person tested positive for COVID-19? YES / NO Date tested: | | | | | | |
| Is the person a suspected case of COVID-19? YES / NO | | | | | | |
| Is the person shielding? YES / NO | | | | | | |
| Is this person in self-isolation? YES / NO | | | | | | |
| **Referral destination:** *\*delete as applicable* | | **Service required:** *\*delete as applicable* | | | | **Professions required:** *\*delete as applicable* |
| * Barnsley | | * Early Supported Discharge | | | | * Clinical Psychology |
| * Bassetlaw | | * Community Stroke Team | | | | * Dietetics |
| * Chesterfield | | * Intermediate Care | | | | * Medical |
| * Doncaster | | * 6/52 review | | | | * Nursing |
| * Rotherham | | * 6/12 review | | | | * Occupational Therapy |
| * Sheffield | | * Other | | | | * Physiotherapy |
| * Other/OOA | |  | | | | * Speech & Language Therapy |
|  | |  | | | | * Social care |
|  | |  | | | | * Other |
| **SECTION 4: MEDICAL HISTORY:** | | | | | | |
| **Date of Stroke:**  Relevant Details of Stroke: (Thrombolysis / CT / MRI / Diagnosis) | | | | | | |
| **Past Medical History:** | | | | | | |
| **Current Medication:** TTO / Electronic Prescription Attached / Transferred with patient record *\*delete as applicable* | | | | | | |
| **Allergies or Sensitivities:** | | | | | | |
| **Known Risks:** *(e.g. Falls / Infection / Safeguarding Concerns)* | | | | | | |
| **Social History/Circumstances:** | | | | | | |
| **Other Services Involved and Onward Referrals to date:** (*e.g. Social Care / Orthotics / Spasticity Clinic / Splinting / FES / Wheelchairs)* | | | | | | |
| **SECTION 5: PATIENT PRESENTATION:** | | | | | | |
| **Medical Status:**  BP/Pulse: Observation record attached? *YES/NO* *\*delete as applicable* Respiratory status:  Skin Integrity/ Waterlow Score:  Infection status (MRSA, Clostridium Difficile, Loose stools): | | | | | | |
| **Nutrition, Eating, Drinking and Swallowing:**  Dysphagia: YES/NO *Delete as applicable and expand:*  Enteral feeding: YES /NO *Delete as applicable and expand:*  MUST score:  IDDSI Framework (\*delete as applicable)  Fluids: 0 Thin (normal) 1 Slightly thick, 2 Mildly thick, 3 Moderately thick, 4 Extremely thick  Diet: 7 Regular (normal), 6 Soft & bite sized, 5 Minced & moist, 4 Pureed, 3 Liquidised. | | | | | | |
| **Communication:**  Aphasia: YES/NO Receptive / Expressive *Delete as applicable and expand:*  Dysarthria YES/NO *Delete as applicable and expand:*  Other: | | | | | | |
| **Continence:**  Catheter YES/NO *If YES state rationale for catheter in situ:* | | | | | | |
| **Physical Ability:**  Modified Rankin Score: Transfer ability:  Mobility:  Upper/Lower Limb Function:  Tonal issues: | | | | | | |
| **Functional Ability:**  Current Barthel Score:  Assistance required for Washing / Dressing / Toileting: | | | | | | |
| **Cognition:**  Assessment completed: MOCA / OCS / Other *Delete as applicable and detail relevant score:*  Other assessment/relevant details: | | | | | | |
| **Behaviour and Emotions:**  Mood assessment and relevant score:  Any special requirements / considerations: | | | | | | |
| **Sensory:**  Vision: Referred to / assessed by Orthoptist: *Delete as applicable*  Hearing:  Touch/proprioception: Other: | | | | | | |
| **Known Risks:** *(e.g. falls, safeguarding* | | | | | | |
| **Other relevant information:** | | | | | | |
| **SECTION 6: IDENTIFIED PATIENT NEEDS / GOALS:** | | | | | | |
| 1.  2.  3. | | | | | | |
| **Secondary Prevention:** | | | | | | |
| SECTION 7: EQUIPMENT AND CARE PROVISION REQUIRED BEFORE TRANSFER: | | | | | | |
| Equipment in place: | Equipment outstanding: | | | | Action/date: | |
| Care Package in place: *Relevant details* | | | | | | |
| SECTION 8: REFERRER DETAILS: | | | | | | |
| **Date / time Communicated to receiving service that patient is ready for transfer / discharge:**  **Date / time TOC completed:**  **Date/time TOC Sent:** | | | | **Communicated at Daily Teleconference Call:** YES / NO | | |
| **Agreed Date and Time of Transfer/Discharge:** *(if known)* | | | | **TOC completed by:** (*Name / signature / designation / contact email or tel number)* | | |
| *Please attach any additional relevant information/documents.* | | | | | | |