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| --- |
| **Patient Details** |
| Surname:Forename:DOB: | Sex: □ Male □ Female Address/Discharge Address: | Next of Kin (NOK) Name:NOK Relationship & Contact No. |
| Pt Contact Number: | GMS/DPS/LTI/PPSN: | Living Alone? □ **Yes** □ **No**  |
| **Referring Source Details** |
| Referring person & location PHN/GP /Nurse:

|  |
| --- |
| Phone Number: |

 | Date of referral | Time of referral |
| Ward & MRN (Medical Records Number) | Admission date to hospital | Consultant |
| Date to be seen by CIT | GP Name | GP Address & contact details |
| Discharge referral sent to: □ GP □ Physio □ PHN □ OT  | Known allergies |
| Relevant Medical/Surgical/Psychiatric history, treatment received & current diagnosis |
| Copy of prescription supplied? □ **Yes**  □ **No**  | Has patient/NOK consented to CIT service & sharing of information? □ **Yes** □ **No**  | Infection Control Status, MRSA, C-Diff, VRE, Other? |
| Mobility Status | Cognitive Status □ Orientated □ Confused  | Reason for referral to CIT |
| Current vital signs HR \_\_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_\_\_\_ SpO2 \_\_\_\_\_\_\_\_ LTOT Y / N RR \_\_\_\_\_\_\_\_\_ Temp\_\_\_\_\_\_\_\_\_  |
| Any additional Information/ Comments |  |
| **For CIT Office Use**  |
| Has patient been informed of the option to attend CIT clinic for treatment? □ **Yes** □ **No**  |

Are there any safety issues CIT staff need to be aware of for home visits**? □ Yes □ No**

Any additional CIT Office Information/ Comments