|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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