# COMMUNITY MATRON REFERRAL FORM

**Fax: 01695-588420 Tel: 01695-588591**

| **PATIENT DETAILS** | **G.P** | **CARER/NEXT OF KIN** |
|---|---|---|
| **Name:** | **Name:** | **Name:** |
| **Address:** | **Surgery:** | **Address:** |
| | **Tel:** | |
| **Postcode:** | **Fax:** | **Tel:** |
| **Tel:** | | |
| **DOB:** | **N.H.S. number:** | |

**REASON FOR REFERRAL**

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***Please attach recent: Patient Summary/ Current Medication /Investigation Results***

**REFERRAL CRITERIA**

**ESSENTIAL –** the patient must be**:**

**-Registered with a West Lancs GP and over 18**

**-Have had 2 or more unplanned attendances to A&E or admissions to hospital in the past 6 months, associated with their long-term condition(s).**

**-Diagnosis of Two or More Long Term Conditions:**

**COPD Heart Failure Diabetes CVD Other (please name)**

**ADDITIONAL –** the patient **must** have one or more of the following please tick

- **On multiple medications (please attach)**
- **Recently bereaved and at risk of deteriorating health**
- **High intensity social services package and lives alone**
- **Has become medically unstable over past 2 months**
- **3 or more unplanned home visits from a GP in relation to a LTC in past 6 months**
- **Has difficulty accessing services**
- **2 or more falls in past 6 months**

**Please state any other health or social care services currently involved:**

**Any known allergies-**

**EXCLUSION CRITERIA**

- **primary diagnosis of dementia**
- **severe and enduring mental health conditions**

**Lives alone YES/ NO Patient aware of referral YES/NO Carer aware of referral YES/NO**

**RISK to Community Matron Staff relating to patient/carer/home environment YES/NO**

**If YES please state nature of risk:**

**MRSA status +ve / -ve**

***Suitability for community matron input will be determined following discussion with the referrer, if necessary.***

| **Referrer Name:** | **Team/ Service** |
|---|---|
| **Designation:** | |
| **Telephone:** | **Base:** |
| **Signature:** | **Date:** |