BHfH No: _____________

Haringey Home from Hospital Service

Patient Referral Form

The Home from Hospital service is open to receive referrals - Monday to Sunday, from 10am to 5pm. We will endeavour to respond to your referral within two hours of receiving it within the specified working hours.

Patient details

NHs number		**NOK**	
First name		**Contact Details**	
Surname		**Named GP**	
Date of birth		**GP Postcode & Tel**	
Address			
Post code			
Tel. number		**Mobile number**	
Email			
Gender			
Ethnicity			
Interpreter	**Yes / No**	If yes, language	

Referrer details

Full names	
Job title	
Hospital	
Ward	
Tel number/ mobile	
Email	
Date of this Referral	
Discharge date	

Further information

Reason for Hospitalisation:

Reason for your referral:

Has patient consented to be referred to us? Yes / No

How did you hear about this service?

Please email this referral form to: marcelle@bridgerenewaltrust.org.uk; or catherinet@bridgerenewaltrust.org.uk, or call 020 8442 7651. Home from Hospital Service, The Bridge Renewal Trust, Laurel's Healthy Living Centre, 256 St Ann's Road, Tottenham, London N15 5AZ .

bridge
renewal trust
for happy and healthier communities

Home from Hospital Patient Assessment Form

The service is for Haringey residents 18 years old and over on discharge from A&E and inpatient hospital beds at the Whittington and North Middlesex Hospitals.

To receive the service people in hospital must meet <u>all</u> of the following criteria:

	Yes	No
1. Resident of Haringey and aged or over		
2. Requiring discharge from Whittington or North Middlesex Hospitals		
3. Give consent or have been determined that it is in the patient's best interests to access the service		
4. Would benefit from practical support at home but <u>not</u> including personal hygiene, domestic cleaning or laundry		
5. Home and social situation deemed not at risk		
6. Able to be safe at home alone with this service		
7. No longer requiring acute medical care		
8. Money available for basic amenities (food, transport, fuel)		
9. At risk of hospital admission / readmission if no support is provided		
10. Worried about returning home and / or live alone and have no apparent support from family or friends		

Name of Referral Co-ordinator ____________________

Date ________________

Signature ________________

<u>For Office use</u>

If patient is eligible, please provide name of allocated Home from Hospital Worker case worker/trained volunteer:

____

If patient is <u>not</u> eligible, please provide detail of onward referral agency (if any):

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Date:____________________