Barcode

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Emergency care referral form from age-related residential care

Waikato Emergency Department associate charge nurse manager, number 021 549 857.

Patient Label

Name: ____________________

NHI: ______________ DOB: ______________ dd/mm/yy

Address: ____________________

GP: (Name/contact) ____________________

or patient details

Immediately before transfer patient was assessed by registered nurse / general practitioner / care giver
To discuss patient call

______________________ (name and designation)
on: ______________________ (number)

Resident receives:
☐ Hospital level care ☐ Rest home level care
☐ Secure dementia care ☐ Psycho-geriatric care
☐ Nurse on site 24/7 ☐ Nurse on-call only

Patients 1st preferred contact (name and telephone number, relationship)

Has contact been notified of transfer to ED? ☐ Yes ☐ No
Contact going to ED? ☐ Yes ☐ No

Patient 2nd preferred contact (name and telephone number, relationship)

Has contact been notified of transfer to ED? ☐ Yes ☐ No
Contact going to ED? ☐ Yes ☐ No

Alerts

Allergies:

Infection control:

☐ Pressure injury Location: ______________________

☐ Falls risk ☐ Unsafe swallow ☐ Can not see ☐ Can not hear ☐ Can not understand

Situation - What is happening?

Patient has new/increased ☐ confusion/aggitation ☐ weakness/fatigue ☐ incontinence ☐ falls ☐ drowseyness

Recent change in function ☐ deterioration in ability to complete ADL ☐ stopped eating/drinking

Is experiencing new ☐ generalised pain ☐ is febrile ☐ other

The change in clinical condition causing the patient to come to ED is (describe specific cirucmstances)

This started ______________ (Date dd/mm/yy), ______________ (Time 24 hour) and has been getting ☐ worse ☐ better ☐ not changed

The patient saw GP/NP ______________ (Date dd/mm/yy), ______________ (Time 24 hour). We have been treating the patient with ______________

☐ Has not seen GP/NP ☐ Has been discussed with GP/NP who advised ______________

Background - relevant clinical history

Brief medical history (tick all that apply)

☐ IHD ☐ Heart failure ☐ Hypertension ☐ Renal impairment
☐ Atrial fibriliation (warfarinised/not warfarinised)
☐ Dementia mild / moderate / severe ☐ COPD
☐ Stroke left / right weakness ☐ TIA ☐ Diabetes
☐ Other (specify)

Usual functional state:

☐ Alert ☐ Orientated ☐ Disorientated ☐ Confused
☐ Can follow instruction ☐ Can not follow instruction
☐ Independantly mobile ☐ Mobility assistance x 1
☐ Weight bears ☐ Full hoist ☐ Standing hoist
☐ Needs help ☐ Toileting ☐ Eat/drinking ☐ Bathing
☐ Other (specify)

Other relevant background (e.g. medication change last 10 days, recent admissions)

Advance care decisions: (attach document eg NFR or advance directive)

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Patient Label

Name: ____________________ or patient details

NHI: ____________ DOB: ____________ dd/mm/yy

Address: ____________________

GP: (Name/contact) ____________________

Current medication (complete or photocopy medication chart)

Emergency medicines given: (Date and time)

Medication: Patient has received all medications as prescribed.
Medication times are: ________ (breakfast) ________ (lunch) ________ (dinner) ________ (supper)

Assessment - What do YOU observe and think the problem is?

BP lying	BP stand / sit	P reg / irreg	Resp rate	O_2 saturation	O_2 flow	Temperature	Blood sugar

Bowel last opened	Current weight	Prior weight and date	**Urinalysis**	Leucocytes	Nitrites	Blood
			Specific gravity	Ketones	Bilirubin	Glucose

Other examination/observations/issues noted

I suspect the patient ☐ is acutely unwell ☐ has a fracture ☐ has an infection ☐ is deteriorating
☐ has unmanaged pain ☐ is dying ☐ reacting to medication (name) ____________
☐ other (specify)

Recommendation - What are you sending patient to ED for?

☐ To determine if condition is reversible
☐ To get a recommendation for treatment/care
☐ For assessment of injury
☐ Other (specify)

Emergency Department staff: before returning patient to us please

☐ Provide your treatment recommendation
☐ Talk to our nurse in charge on ____________ (number)
☐ Other (specify)
☐ Identify any medication changes

For your information we have
☐ R/N on site 24/7 ☐ R/N on-call only
☐ We use the End of Life pathway
☐ Our GP visits ☐ Daily ☐ Twice weekly ☐ Weekly ☐ PRN
☐ We **do not** use the End of Life pathway

Check list

Property with patient
☐ Spectacles
☐ Hearing aid (1 or 2)
☐ Denture top / bottom
☐ Walking frame / stick
☐ Other

Documentation with patient (this order)
☐ Relevant GP/NP notes/letter
☐ Medication chart
☐ Advance care plan/ directive/NFR
☐ EPoA
☐ Other supporting documents

Transport arrangements
☐ Patients preferred contact informed of transfer

Date	Time	Name	Designation	Sign