 



**MORAY DISCHARGE TO ASSESS**

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| **Patient Details:****CHI / DOB:****Name:****Address:****Telephone Number:****NOK:****Consent to contact NOK:** [ ]  | **Referrer Name:****Designation and Location:****Telephone / Bleep No:****Date referral form completed:****Estimated Date of Discharge:****Consent for referral obtained** [ ] **Moray Discharge to Assess leaflet issued** [ ] **Patient’s current location** (*Hospital / Ward details*): |
| **Date and Cause of Admission:****Medically Fit for Discharge** [ ] **Discharging Consultant Name:****Date of discussion re: medically fit for D/C:****Weight Bearing Status / Precautions:** | **Past Medical History:****DNA CPR in place: (MUST be completed)****Yes** [ ]  **No** [ ] **Hearing:****Eyesight:****Communication:** |
| **Falls History** (*Falls in the last 6 months? Frequency / Location / CAS in situ?*) | **Cognition:****Mood / Motivation:** |
| **OT and PT Rehabilitation Goals:****1.****2.****3.** | **Home Environment / Social Support:** (*Scanned therapy notes are acceptable*) |
| **Discharge to Assess Health Care Support Worker initial input request:** (*Number of visits, details of support required. Personal care, meals, med prompts, physio exercises*)**AM -****LUNCH -****TEA -**  |
| **Functional Status** |
|  | **Baseline Ability** | **Current Ability** | **Comments / Equipment Used** |
| **Mobility** |  |  |  |
| **Stairs** |  |  |  |
| **Chair Transfers** |  |  |  |
| **Bed Transfers** |  |  |  |
| **Toilet Transfers** |  |  |  |
| **Shower / Bath Transfers** |  |  |  |
| **Washing**  |  |  |  |
| **Dressing** |  |  |  |
| **Continence** |  |  |  |
| **Medication** (*support prompt only*) |  |  |  |
| **Kitchen Tasks** |  |  |  |
| **Domestic Tasks** |  |  |  |

Codes: N/A – Not Applicable N/Ax – Not Assessed I – Independent S – Supervision A – Assistance (of 1 or 2) D – Dependent

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| **Additional Information** (eg: lone working considerations, safeguarding concerns, Keysafe details): |

**Send referrals to:** gram.moraydtoa@nhs.scot