NHS Grampian

HOSPITAL DISCHARGE TEAM

ASSESSMENT SCREENING TOOL

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HEALTH & SOCIAL CARE MORAY

WARD: **DATE OF ADMISSION:** **DATE OF HUB REFERRAL:**

PATIENT DETAILS (Affix label)	NEXT OF KIN
Name: Address: Postcode: CHI: Telephone Number: Age:	Name: Address: Postcode: Relationship: Telephone Number:
REGISTERED GP	**REASON FOR REFERRAL TO HUB**
Practice Name	

HISTORY OF PRESENT CONDITION (Admission reason) AND TREATMENT

PAST MEDICAL HISTORY

DNACPR Insitu YES ☐ Date Signed _____ NO ☐

AWI Insitu YES ☐ NO ☐ POA Proof Seen ☐

Patients name ..... CHI: .....

Skin / Wounds	Medication – Including High Risk Medication Injection issues

ALLERGIES	MEDICATION MANAGEMENT?

SOCIAL HISTORY

Lives: ☐ Alone ☐ With Spouse / Partner ☐ With Family

☐ Other – State: .....

ACCOMMODATION		SOCIAL CARE (existing services, support, family, friends, i.e. day care, clubs, shopping financial issues etc)
☐ Own ☐ Rented ☐ Council	☐ Sheltered ☐ Care Home ☐ Other	☐ Telecare ☐ Community Alarm ☐ Other (please state)

FUNCTIONAL ABILITY (current status)

	PRIOR TO ADMISSION	CURRENT ABILITY
Mobility		
Transfers (eg Chair, Toilet, bed)		
Personal Care		
Meal Prep		
Other (please state)		
Stairs	**Internal** ☐ Yes ☐ No	**External** ☐ Yes ☐ No

NUTRITION		CONTINENCE
(any dietary requirements or supplements?)	**Catheter Type** Short Term ☐ Long Term ☐ Date Inserted ☐	**Continence products used** **Stoma Care**

Patients name ..... CHI: .....

Dressings required? Sutures / clips to be removed? Tissue viability care plan? Pressure issues	
Palliative Care	**Cognition**
PPS Score :	**4AT** ☐
Identified Issues Preventing Discharge Home?	
Rehab Goals (please fill this in after PT / OT assessment)	

Patient aware of referral ☐ **Patient consented to referral** ☐

Patient consented to Information Sharing with Service Providers ☐

Patient known to Ward Occupational Therapist ☐ **Physiotherapist** ☐

Patient known to Social Work ☐

Person completing Form: _____

Contact Number: _____

Date: _____