

**Manchester Case Management North Locality**

***( Previously known as High Impact Primary Care & Active Case Managers*)**

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **PATIENT DETAILS** | | | | | | | | | | | |
| **Name**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **PATIENT DETAILS** | | | | | | | | | | | | | **Name** |  | | **Emergency Contact (family member, friend, neighbour, carer/s)** | | | | | | | | | | **Address** |  | | **Name** | | | |  | | | | | | **Home Telephone** |  | | **Relationship** | | | |  | | | | | | **Mobile Telephone** |  | | **Contact Telephone** | | | |  | | | | | | **Age** |  | | **Main Language** | | | |  | | | | | | **Date of Birth** |  | | **Interpreter required?** | | | |  | | | **No** | | | **NHS Number** |  | | **Other communication needs? (Please state)** | | | | | | | | | | **GP DETAILS** | | | | **Name** |  | | | **Address** |  | | | **Telephone** |  | | | **REFERRER DETAILS** | | | | | | | | | | | | | **Name** |  | | | **Contact Number** | |  | | | | | | **Date of referral** |  | | | | **Does the patient know they are being referred?** | | | | | **Yes** | | | |  | | | | **Does the patient live alone?** | | | | | **Yes** | | | |  | | | | **Are there any safety issues?** | | | | |  | | | | **No** | | | | **Is the patient housebound?** | | | | |  | | | | **No** | | | | **Key Code** | | | | |  | | | | | | | | **REASONS FOR REFERRAL:**  **Please give as much information as possible explaining the patient’s needs. This will enable us to triage the referral. Please include relevant information / reports.**  **Recently unwell with gastro symptoms (under crisis) dehydrated/drop in egfr. Pancreatic enzymes raised ? cause.**  **Not using correct inhalers for COPD/overusing rescue medication. Would benefit from support and education to manage long term conditions**  **Family concerned. Good family support** | | | | | | | | | | | | | **Medical History / Chronic Conditions / Allergies**  **COPD TIA Spinal Stenosis IHD CKD stage 3** | | | | | | | | | | | | | **Social history / Risk Factors – wife lives in care home, daughters support with shopping and cleaning ec** | | | | | | | | | | | | | **Please complete all sections of the form. Any incomplete referrals may be returned to the referrer. Please send via Emis referral / email to** mft.northcommunity@nhs.net | | | | | | | | | | | | | **Exclusion Criteria** | | | | | | | | | | | | | **Under 18** | | **In a nursing home** | | **End of life** | | | | **Mental Health Crisis** | | | | |  | | **Emergency Contact (family member, friend, neighbour, carer/s)** | | | | | | | | |
| **Address** |  | | **Name** | | | |  | | | | |
| **Home Telephone** |  | | **Relationship** | | | |  | | | | |
| **Mobile Telephone** |  | | **Contact Telephone** | | | |  | | | | |
| **Age** |  | | **Main Language** | | | |  | | | | |
| **Date of Birth** |  | | **Interpreter required?** | | | | **Yes** | | | **No** | |
| **NHS Number** |  | | **Other communication needs? (Please state)** | | | | | | | | |
| **GP DETAILS** | | |
| **Name** |  | |
| **Address** |  | |
| **Telephone** |  | |
| **REFERRER DETAILS** | | | | | | | | | | | |
| **Name** |  | | | **Contact Number** | |  | | | | |
| **Date of referral** |  | | |
| **Does the patient know they are being referred?** | | | | | **Yes** | | | | **No** | | |
| **Does the patient live alone?** | | | | | **Yes** | | | | **No** | | |
| **Are there any safety issues?** | | | | | **Yes** | | | | **No** | | |
| **Is the patient housebound?** | | | | | **Yes** | | | | **No** | | |
| **Key Code** | | | | |  | | | | | | |
| **REASONS FOR REFERRAL:**  **Please give as much information as possible explaining the patient’s needs. This will enable us to triage the referral. Please include relevant information / reports.** | | | | | | | | | | | |
| **Medical History / Chronic Conditions / Allergies** | | | | | | | | | | | |
| **Social history / Risk Factors** | | | | | | | | | | | |
| **Please complete all sections of the form. Any incomplete referrals may be returned to the referrer. Please send via Emis referral / email to** mft.northcommunity@nhs.net | | | | | | | | | | | |
| **Exclusion Criteria** | | | | | | | | | | | |
| **Under 18** | | **In a nursing home** | | **End of life** | | | | **Mental Health Crisis** | | | |