18. Appendix A - Referral form For IV's in the Community

Upon receipt of this form, the Rapid Response Team (formerly known as ICT), will act as the single point of access for all IV referrals and liaise with the referring orgnaisation/s.

All sections to be completed by referring Dr/Clinician and fax to 0208 390 6923.

PATIENT DETAILS	
Name: Date of Birth: Hospital No: Address: Telephone No: Mobile No:	GP: Address: Telephone No:
Next of Kin: Relationship: Address: Contact No's:	District Nurse: Based at: Contact No:
Allergies (Patients that have suffered a previous anaphylactic reaction must not be accepted for IV antibiotics in the community):	
DOCTORS DETAILS	
Referring Doctor: Telephone No: Bleep No: Address/Ward: Consultant:	Date of Referral: Expected Date of Discharge:
HOSPITAL ADMISSION DETAILS	
Date of Admission: Reason for Admission:	
Details of Current Admission:	
Reason for Referral:	
Current Medication:	
Relevant Past Medical History:	

REFERRAL form FOR INTRAVENOUS ANTIBIOTICS IN THE COMMUNITY

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TO BE COMPLETED BY REFERRING DOCTOR AND FAXED TO Rapid Response Team (Single point of access for IV referrals).

Patients Name:	**Date of Birth:**	
The Patient:	**Yes**	**No**
• Medically stable and well enough for discharge		
• **Fully** informed consents to home intravenous treatment		
• No cognitive impairement?		
• Can understand and comply with treatment regime, (e.g. elevation of limb, time off work for resting, compliance with regime)		
• Has support from family or carer (The family/carer agrees that they will take the patient to A&E Kingston if any problems occur)		
• Has adequate venous access		
Home Setting: If no to these questions unable to take referral		
• Has access to a telephone		
• Has running water and electricity in house		
• Has no other known problems with home environment		
The Medicine:		
• Cannot be administered by any other route		
• Manageable in the community setting (procedure no longer than 30 minutes – longer visits may be negotiated)		
• Is prescribed for a licensed indication (If no, confirm reason for use)		
• Is PICC Line in situ		
• Has no special monitoring or safety requirements		

Patient Accepted (continue with Section 2) YES / NO

Patient Declined / Deferred: (Please give reason and any follow up required)

Signature: **Print:** **Date:**

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REFERRAL CHECKLIST FOR IV's IN THE COMMUNITY

To Be Completed By Referring Doctor And Faxed To Rapid Response Team (Single Point Of Access For All IV Referrals).

Patient Name:	**Date of Birth:**
TREATMENT	
Intravenous Antibiotics to be Administered:	
Date and Time Antibiotics Commenced:	
Date of Review of Treatment if Needed:	
Expected Date of Completion of Treatment:	
BLOOD MONITORING	
Is Blood Monitoring Required? Yes / No	If yes, what blood monitoring is required and how often?
Who will review the results?	
IV ACCESS	
Type: Access line in situ? Yes / No	Date of Insertion: Comments:
ANAPHYLAXIS RISK ASSESSMENT	
Patients that have suffered a previous <u>anaphylactic reaction</u> must <u>not</u> be accepted for IV antibiotics in the community	
Known Allergies:	
If the patient has had a previous allergic reaction, what type of reaction was it?	
Is there any cross sensitivity between the medicine to be administered and the substance that caused a previous reaction?	
Has the patient had the prescribed antibiotic before (orally or intravenously)?	
How many doses of the current regime have been administered?	
PRESCRIBERS DETAILS	
Referring Doctor to be Contacted for Advice:	
Contact No's:	Bleep No:
Doctors Signature:	**Print:** **Date:**

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Equipment to be sent home on discharge from hospital:

- [ ] Dressing pack X 2
- [ ] Transparent dressings X 2
- [ ] 10ml syringes X 10
- [ ] Blue needles X 10
- [ ] Clinell wipes X 5
- [ ] 100ml saline bags as required
- [ ] Sharps bin
- [ ] Bionectors
- [ ] IV drug for duration of therapy IV reconstitution solution for duration of therapy (e.g. water for injection, mini bags & giving sets)

If you have any queries re this list please contact The Rapid Response Team on 02082747088