SAFEHANDS NURSING CARE
Nurse-Led Complex Care

contact@shnc.org.uk
020 8050 0098

Referral Reference (SHNC Use): _____

Clinical Referral & Package Request Form

For referrals, package enquiries and hospital discharges — SafeHands Nursing Care Ltd

Please complete as much information as is available. Missing information will not delay an initial clinical review.

REFERRER

Organisation

Referrer's Name

Job Title

Telephone

Email

CLIENT

Name

Date of Birth

NHS Number *(optional)*

Address

Preferred Contact

☐ Client ☐ Family ☐ Case Manager ☐ Deputy

☐ Other _____

CURRENT LOCATION

☐ Home ☐ Hospital ☐ Rehabilitation Unit

☐ Care Home ☐ Hospice ☐ Other _____

Current Care Provider *(if applicable)*

Expected Discharge Date *(if applicable)*

FUNDING

☐ ICB / CHC ☐ Case Managed ☐ Local Authority

☐ Private ☐ Personal Health Budget ☐ Other _____

REASON FOR REFERRAL / SUMMARY OF CARE NEEDS

REQUIRED START DATE

REFERRAL PRIORITY

☐ Urgent (within 24 hours) ☐ Within 72 hours ☐ Planned package

☐ Future enquiry

CLINICAL REQUIREMENTS

- ☐ Tracheostomy
- ☐ Suction
- ☐ JEJ
- ☐ Diabetes Management
- ☐ Stoma Care
- ☐ Neurological Condition
- ☐ Palliative Care
- ☐ Ventilation
- ☐ Cough Assist
- ☐ Medication Administration
- ☐ Catheter Care
- ☐ Pressure Care
- ☐ Behaviour Support
- ☐ Other _____
- ☐ Oxygen
- ☐ PEG
- ☐ Buccal Midazolam
- ☐ Bowel Care
- ☐ Spinal Cord Injury
- ☐ Learning Disability

TYPE OF PACKAGE REQUIRED

- ☐ Live-in Care
- ☐ Waking Nights
- ☐ Day Support
- ☐ Respite
- ☐ 24-Hour Care
- ☐ Sleeping Nights
- ☐ Double-up
- ☐ Hospital Discharge

Estimated Hours

Per day: _____ Per week (if known): _____

MENTAL CAPACITY

- ☐ Has capacity
- ☐ Lacks capacity
- ☐ Capacity fluctuates
- ☐ Not known

SUPPORTING DOCUMENTATION AVAILABLE

- ☐ Care Plan
- ☐ Risk Assessments
- ☐ MAR
- ☐ Clinical Protocols
- ☐ Moving & Handling
- ☐ DNACPR / ReSPECT
- ☐ SALT Guidelines
- ☐ Tissue Viability Plan
- ☐ Behaviour Support Plan
- ☐ Other

Known allergies? *(optional)*

KNOWN RISKS

- ☐ Falls
- ☐ Seizures
- ☐ Pressure Damage
- ☐ Infection
- ☐ Challenging Behaviour
- ☐ Safeguarding
- ☐ None Known

Has the client been assessed as requiring two carers?

☐ Yes ☐ No ☐ Variable

ADDITIONAL INFORMATION

INTERNAL SHNC USE ONLY

Received by	Clinical Triage Completed	Capacity confirmed

Outcome: ☐ Accepted ☐ Declined ☐ Further information required

REFERRAL CHECKLIST

- ☐ Referral reason completed
- ☐ Funding confirmed (if known)
- ☐ Clinical needs identified
- ☐ Supporting documents attached (if available)

Supporting documentation can be sent after the referral has been received. If any information is unavailable at the time of referral, please submit what you have and we will work with you to obtain the remaining documentation.