**Community Matron Referral form**

**Patient must meet both of the criteria below**

❑ **The patient has highly complex health problems associated with multiple Long Term Conditions (usually 2 or more), and requires Community Matron Intervention to ensure effective case management and care coordination.**

❑ **The patient has 2 or more unplanned hospital admissions into secondary care within the previous 12 months.**

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| Patient Name |
| DOB |
| NHS number |
| Contact Number |
| Address |
| Referral Source |
| Referrer name and contact number |
| Diagnosis |

|  |  |  |
| --- | --- | --- |
| RAG Rating | Patient stratification | Explanation to meet criteria  This must be completed |
| Red  Definition to prevent further deterioration or hospital admission | Current exacerbation of LTC  At high risk of admission  Increased access to services i.e A&E, GP. OOH  Patient being discharged on treatment i.e antibiotics and require follow up within days-weeks  Medically unstable- for example hypertension, increase in anxiety leading to breathlessness, abnormal blood results that impacting on LTC | Dates of admission |
| Amber | High number of attendances to A&E.  Frailty that may need co-ordination of care package  Increase in falls  Prolonged stay in hospital  Bereavement that may be having an impact on condition.  3 or more unplanned GP visits in relation to LTC in last 6 months |  |
| Green | Housebound patient requiring assessment of Multiple long term conditions.  Discussion at LTC, stable patients that may require CM input and management plan initiating.  Polypharmacy review |  |
| Current Medication | Co-morbidities | Any risk to visiting health professionals |

**Please note** - if appropriate, could you please attach any medical history, Medication, or Hospital Discharges please **email to CCC rgh-tr.ccc@nhs.net**