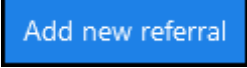# Adding a Referral Quick Reference Guide

When you accept a referral, you must add it to **Community** for allocation to your **Community Team**.

To add a referral to **Community**:

1. From the **Community Home** screen, select **Referral Inbox** .

2. Select **Add new referral** .

3. The **Patient Search** section displays, find the patient required in the usual way. Using the patient's CHI, NHS or H+C number provides you with the most accurate results, see Searching for a Patient on page 4 for details if required.

4. If you have no legitimate relationship with the patient you select, the **No legitimate relationship** screen displays, select the reason you are accessing the patient from the list available and select **OK**.

5. Complete the following sections as required:

Patient Demographics

The **Patient Demographics** section displays, check and update any details required.

> **Remember** - Do not forget to add a **Temporary Address** if appropriate.

> **Note** - Mandatory entries are marked with a red asterisk *.

Patient Warning

Tick **Patient Warning** and enter the details of the warning if appropriate, for example, Hard of hearing or Aggressive dog.
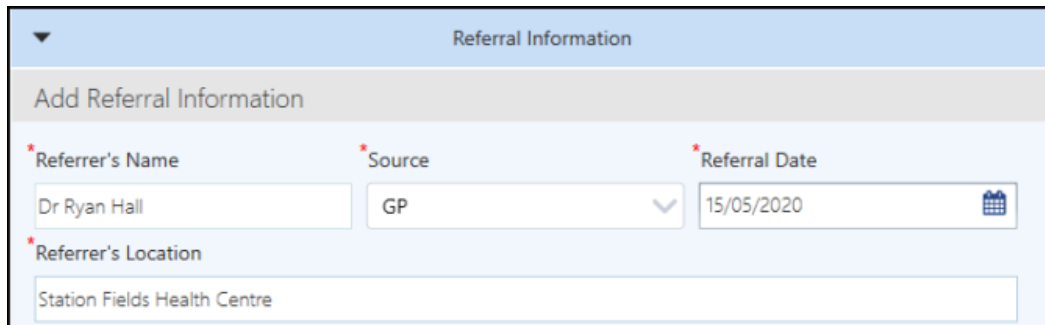
Emergency Contact

The **Emergency Contact** section displays, enter any details as appropriate, see Emergency Contact on page 5 for details if required.

DNA CPR

The **DNA CPR** section displays, tick and complete options as appropriate, see DNA CPR on page 6 for details.

Referral Information

The **Referral Information** section displays, enter the referrer's name, the source of the referral, referral date and referrer's location:
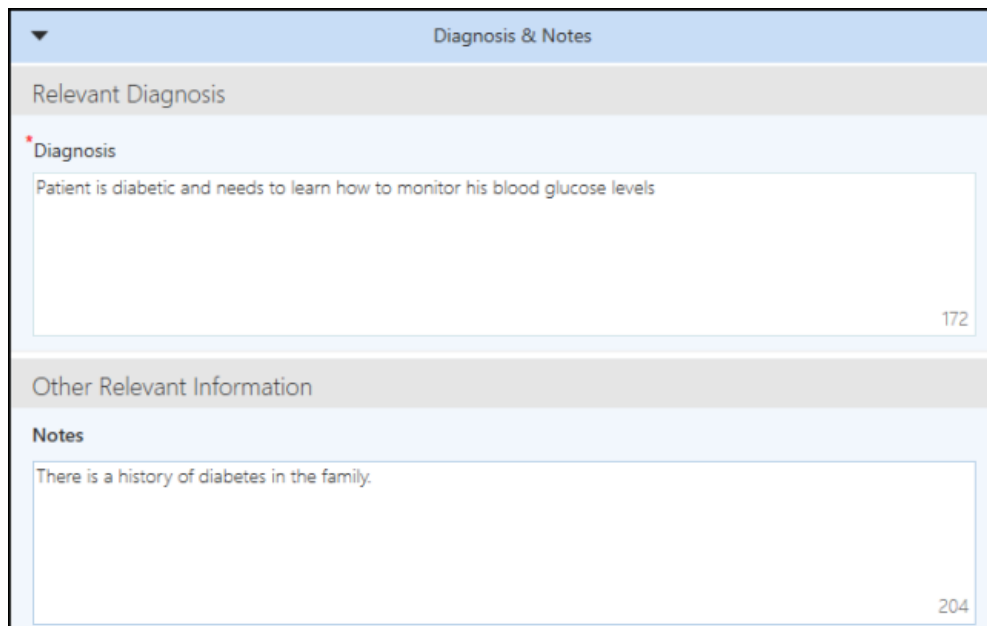

Accepted/Rejected Referral History - Displays any accepted/rejected referrals for this patient.

Diagnosis & Notes

The **Diagnosis & Notes** section displays, enter the diagnosis and other relevant information for the patient:

- **Diagnosis** - Enter the referral reason and the care being requested.
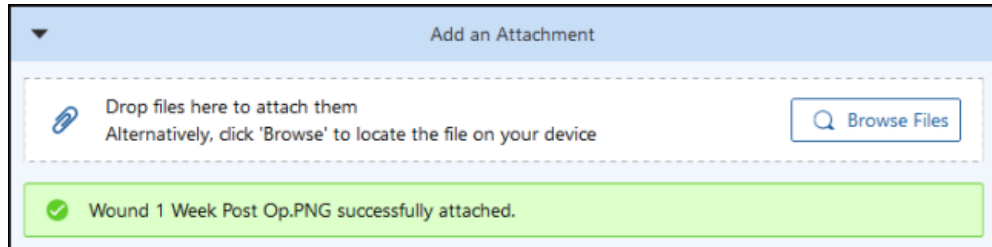- **Notes** - Enter any additional information required:

Current Appointments

The **Current Appointments** section displays any scheduled appointments for the selected patient.

Add an Attachment

To add an attachment when creating a referral, either:

- Locate the required file on your computer and from your file explorer, drag and drop the file into the designated area on the screen, or

- Select **Browse Files** [Q Browse Files], locate and select the file required:

▼	Add an Attachment
🔗 Drop files here to attach them Alternatively, click 'Browse' to locate the file on your device	Q Browse Files
✅ Wound 1 Week Post Op.PNG successfully attached.	

✏️ **Note** - You can add more than one file to a referral, but they must not exceed 2mb.
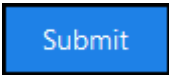
Approval

The **Approval** section allows you to accept or reject the referral you are adding:

- **Status**:

  - Select **Accept** to accept the referral and then from Care Plan, select from the available list as appropriate for this referral.

  - Select **Reject** to reject the referral and then from Reason for Rejection, select from the available list as appropriate for this referral.

If you are recording a referral that you are rejecting, tick **I confirm that the data entered in correct at time of referral** and then select **Submit** to finish and save this referral.
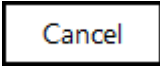
Interventions

An **Intervention** details the action being requested. You must add an intervention to a referral before it can be accepted**.** See Adding an Intervention on page 7 for full details.

6. Tick **I confirm that the data entered in correct at time of referral** to confirm you have checked the details are correct.

7. Select **Submit** [Submit] to save this referral ready for allocation to a team member(s).

To save the details entered without submitting it for allocation to a team member, for example, if more information is required, you can select **Save as Draft** $\boxed{\text{Save as Draft}}$, see Saving and Retrieving Draft Referrals on page 10 for details.
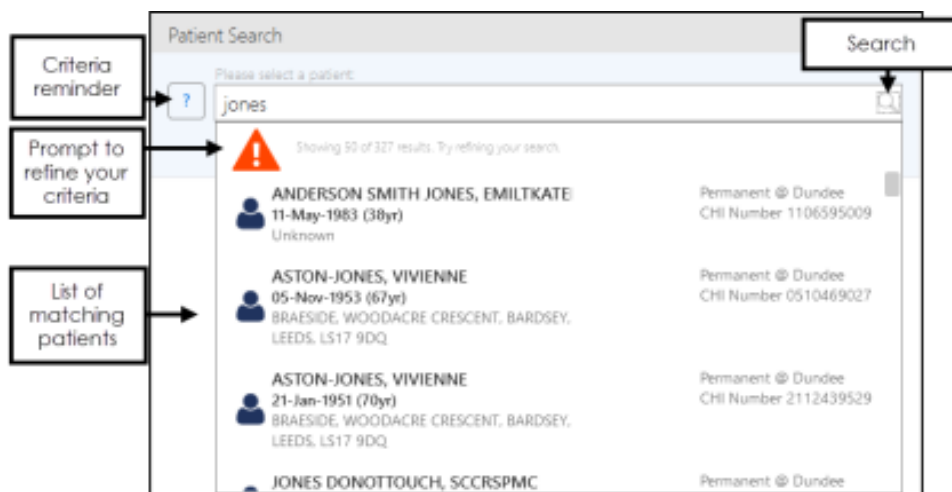
You can select **Cancel** $\boxed{\text{Cancel}}$ at any point while adding a referral to abandon it.

Searching for a Patient

To search for a patient:

1. From the **Patient Search** section, enter any of the following patient details:

    - Surname, for example, *Smith*.
    - Surname, First name (note the comma), for example, *Smith, John*.
    - Surname First name, for example, *Smith John*.
    - Surname DOB (DD-MMM-YYYY), for example, *Smith 05-04-2001*.
    - DOB (DD-MMM-YYYY), for example, *05-04-2001*.
    - Surname, First name DOB (DD-MMM-YYYY), for example, *Smith, John 05-04-2001*.
    - NNNNNNNNN (CHI or NHS), for example, *1231231234*.

2. Select **Search** $\boxed{Q}$.

3. Select the patient required from the list:

> 🖊 **Note** - If your search returns more than 50 patients, a prompt displays suggesting you refine your search.
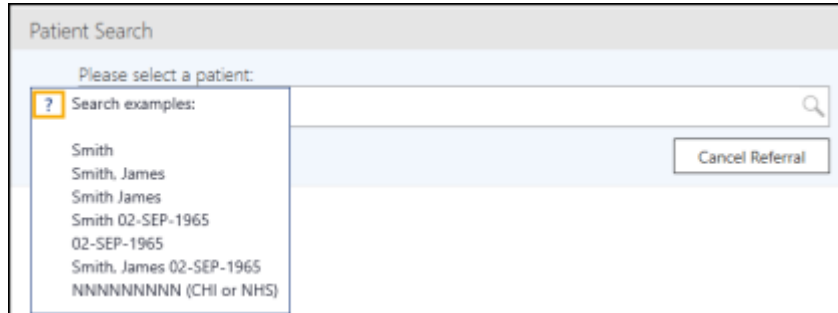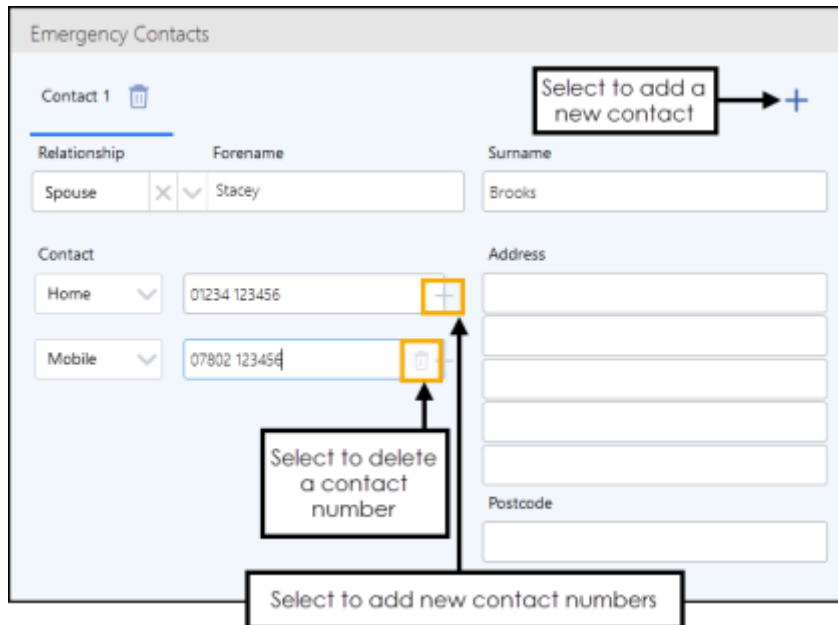
> 💡 **Training Tip** - Using the patient's CHI, NHS or H+C number provides you with the most accurate results.

Select the **Question Mark** ? to display a reminder of the search criteria:

Emergency Contacts

If you have details of a patient's emergency contacts, you can enter them in the **Emergency Contacts** section of a referral:

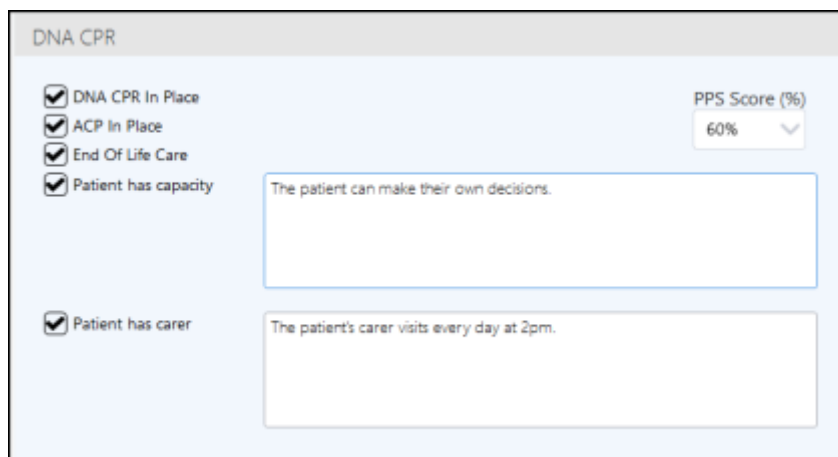- **New Emergency Contact** - Select **Plus** ⊞ in the top right corner to add a new emergency contact and complete the details as appropriate.

- **Contacts** - Select **Plus** ⊞ at the end of the **Contact** line to add new contact details, or over type what is there to update it.

- **Removing** - Select **Delete** 🗑 at the top of the section to delete an entire contact, or alongside a number to delete that specific detail.

DNA CPR

If any **Do not attempt Cardiopulmonary Resuscitation (DNA CPR)** details are in place for a patient, they can be recorded in the **DNA CPR** section of a referral or the **Patient Care** screen.

To complete the **DNA CPR** section:

1. From the **DNA CPR** section complete the following:

   - **DNA CPR in Place** - Tick to indicate a clinician has completed a **Do not attempt Cardiopulmonary Resuscitation** form stating that in the event of the patient suffering cardiac arrest, resuscitation should not be attempted by health care professionals in attendance.

   - **ACP In Place** - Tick to indicate a **Anticipatory Care Plan** has been developed for the patient who is at risk of recurring hospital admissions due to a chronic disease.

   - **End Of Life Care** - Tick to indicate an **End of Life Care** plan is in place for a terminally ill patient and outlines what has been arranged for the time leading up to their death.

   - **Patient has capacity** - Tick to record any details on the patient's capacity, for example, a patient with severe dementia may not be able to make their own decisions for their care.

   - **Patient has carer** - Tick to indicate the patient has a carer and enter any details required, for example, a patient has a carer that comes each day at 14:00.

   - **PPS Score** - Select from the available percentages, this value is a calculated **Patient Palliative Score** for the patient, the closer to 100% they score, the more care they require:
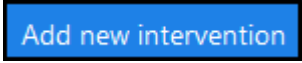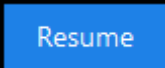
Adding an Intervention
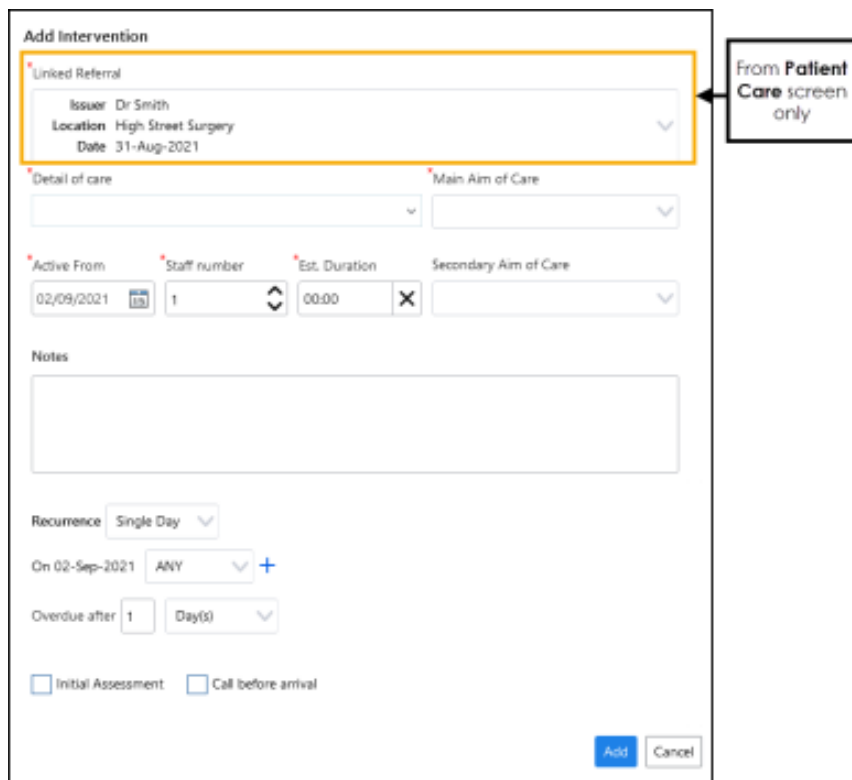
An **Intervention** is the part of a referral that specifies the action being requested, you cannot submit a referral without at least one **Intervention** recorded.

To add an **Intervention** to a referral:

1. Either:

   - From **Referral Inbox** when adding a referral, select **Add new intervention** Add new intervention , or

   - From **Referral Inbox** select a draft referral to update, select **Resume** Resume and then **Add new intervention** Add new intervention , or

   - From **Patient Care** , select the patient required, Select the **Interventions** tab, highlight the referral required and select **Add Intervention** Add Intervention .

2. The **Add Intervention** screen displays:

3. Complete the following as required:

- **Linked Referral** - Displays from the **Patient Care** screen only, completes with the referral this **Intervention** is linked to. Check this is the correct referral and if not, select **Cancel** and select the correct referral before continuing.

- **Detail of Care** - Select the arrow to see available categories, highlight the appropriate category and then select the sub-category of the detail of care being requested.

- **Main Aim of Care** - Select the aim of this **Intervention** from the list available.

- **Active From** - Defaults to today, update the date to start the **Intervention** if required.

- **Staff Number** - Defaults to one, update the number of team members required to complete the intervention. If more than one member of the team is specified, it displays on the intervention .

- **Est. Duration** - Enter the time you estimate the **Intervention** to take, use hh:mm, for example, 01:15 for 1 hour and 15 minutes.

- **Secondary Aim of Care** - If appropriate, select from the list available.

- **Notes** - Enter any details relevant to the **Intervention**, any notes display on the **Individual Caseload** printout of the **Intervention**:

- **Recurrence** - Enter how many visits and how often this intervention is to be scheduled:

  - **Single Day** - Select to set a visit(s) on an individual day, the date defaults to the **Active From** date and can be updated from there.

    Select the time of day required from ANY, AM, PM, EVE, NIGHT or CUSTOM, if you select CUSTOM between time frame options display, complete using 24 hour clock, for example 14:00 - 15:00.

    For subsequent visit(s) on the same day, select **Plus** alongside the time of day and complete as above.

    From **Overdue after**, select from the options available the time frame that, should it not be completed, this **Intervention** should display as overdue.

- **Daily** - Select to set a visit on multiple days.

  In **Every**, select the day frequency, for example, **1** results in a visit every day, **3** is a visit every third day.

  Select the time of day required from ANY, AM, PM, EVE, NIGHT or CUSTOM, if you select CUSTOM between time frame options display, complete using 24 hour clock, for example 14:00 - 15:00.

  For subsequent visit(s) on the same day, select **Plus** ⊞ alongside the time of day and complete as above.

  From **Overdue after**, select from the options available the time frame that, should it not be completed, this **Intervention** should display as overdue.

  From **Until**, select an end date for this intervention where one is available.

- **Weekly** - Select to set weekly visits.

  In **Every**, select the weekly frequency, for example, **1** results in weekly visit(s), **3** is three weekly visit(s). Each week can contain multiple visits.

  The option to select the day of the week and the time frame displays, select as required.

  For subsequent visit(s) in the same week, select **Plus** ⊞ alongside the time of day and time and complete as above.

  From **Overdue after**, select from the options available the time frame that, should it not be completed, this **Intervention** should display as overdue.

  From **Until**, select an end date for this intervention where one is available.

4. Select **Add** `Add` to add the **Intervention** to the referral.
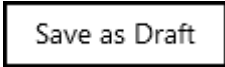

 Note - A referral must contain an intervention before it can be accepted. There is **no limit** on the number of interventions that can be created.

Saving and Retrieving Draft Referrals

At any point during the creation of a referral, it is possible to save the referral as a draft and return to it at a later point to complete or delete it.

To save a referral as a draft:

1. Create a referral in the usual way, see Adding a Referral on page 1 if required.

2. After selecting a patient, select **Save as Draft** Save as Draft .

3. The referral is then saved as a draft until you return to **resume or delete** it.

To retrieve a draft referral:

1. From **Referral Inbox** , find and highlight the draft referral required from the left hand column.

2. The referral displays in the **Referral Options** section of the screen:

Draft referral as saved by KIRBY, Michael on 1/24/2019 1:53:11 PM

Patient Demographics						
Forename:	RITA	Gender:	Female	Area:	Community District North	
Surname:	COOPER SMITH	Ethnicity:	Other British			
		Religion:		Telephone:		
Known as:		Date of Birth:	11-Mar-1950			
		CHI Number:	1102437921			

Referral Options

Resume   Delete

3. Select either:

- **Resume**, to complete the referral details, or
- **Delete, to remove the referral from the system.**

> ✏ **Note -** The draft referral remains in the referral inbox until it has been either completed or deleted.