

ALL FIELDS MUST BE COMPLETED, otherwise patient will not be accepted

Patient Details		
Surname:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Next of Kin (NOK) Name:
Forename:	Address/Discharge Address:	NOK Relationship & Contact No.
DOB:		
Pt Contact Number:	GMS/DPS/LTI/PPSN:	Living Alone? <input type="checkbox"/> Yes <input type="checkbox"/> No
Referring Source Details		
Referring person & Ward/Hospital/PHN/GP	Date of referral	Time of referral
Ward & MRN (Medical Records Number)	Admission date to hospital	Consultant
Date to be seen by CIT	GP Name	GP Address & contact details
Discharge referral sent to: <input type="checkbox"/> GP <input type="checkbox"/> Physio <input type="checkbox"/> PHN <input type="checkbox"/> OT	Known allergies	
Relevant Medical/Surgical/Psychiatric history, treatment received & current diagnosis (In addition, please provide discharge summary at time of discharge)		
Copy of prescription supplied? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has patient/NOK consented to CIT service & sharing of information? <input type="checkbox"/> Yes <input type="checkbox"/> No	Infection Control Status, MRSA, C-Diff, VRE, Other?
Mobility Status	Cognitive Status <input type="checkbox"/> Orientated <input type="checkbox"/> Confused	Reason for referral to CIT
Current vital signs HR _____ BP _____ SpO2 _____ LTOT Y / N RR _____ Temp _____		
Any additional Information/Comments		
For CIT Office Use		
Has patient been informed of the option to attend CIT clinic for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any safety issues CIT staff needs to be aware of for home visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any additional CIT information/comments: