**This is my Trusted Transfer of Care Document**

**My name is:** Click here to enter text.



If I have to go to hospital this document needs to go with me, it gives the hospital staff important information about me, when I am well.

If my care provider calls to discuss my care the following password will confirm their identity:Click here to enter text.

The Situation, Background, Assessment & Response (SBAR) tool explains the reason why I have been transferred to hospital.

**Attached to my Document are:**

Original - Do Not Attempt CPR [ ]

ReSPECT Form [ ]

Advanced Care Plan Yes/No/N/A

Date last seen by a Health Professional: Click here to enter a date.

Copy of Consent form [ ]  Advanced Decision to refuse treatment (ADRT) Yes/No/N/A

Body Map [ ]  Lasting Power of Attorney (LPA) Included Yes/No/N/A

Copy of current MAR Chart [ ]  Deprivation of Liberty Safeguard (DoLS) in place Yes/No/N/A

Copy of Inter Health and Social Infection Control Transfer Form ☐

This document belongs to me and should follow me throughout my hospital stay.

Please return it with attached documents when I am discharged.

Clinical staff should refer to this document for important information about me.

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| **Personal Belongings transferred from Care Home** | **Tick all that apply** | **If no- reason** |
| Change of clothes |[ ]   |
| Slippers |[ ]   |
| Toiletries |[ ]   |
| Glasses |[ ]   |
| Hearing aid |[ ]   |
| Dentures |[ ]   |
| Personal items/Valuables (specify):  |[ ]   |
| Mobility aids |[ ]   |
| Other (specify): Click here to enter text. |[ ]   |

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| SBAR Tool  |
| Date: Click here to enter a date. |
| **Situation:** (how is my current state & symptoms different from my usual state)? |
| Click here to enter text. |
| **Background:** (how long has this been going on for)? |
| Click here to enter text. |
| **Assessment**: (has a clinical diagnosis been identified? Is there a management plan in place and has it been followed?) |
| Click here to enter text. |
| **Response:** Responding Service Notified ……………… Date……../….…/..…… Time (am/pm) ………………….Actions you were advised to take and those the responding service will perform:  |
| **Any other information/notes**: |
| Click here to enter text. |

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| Date completed: | Click here to enter a date. | By: | Click here to enter text. |

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| **Important contacts for me** |
| Name: | Click here to enter text. |
| Likes to be known as: | Click here to enter text. |
| NHS Number: | Click here to enter text. |
| Date of Birth: | Click here to enter a date. |
| Address: | Click here to enter text |
| Tel No: | Click here to enter text. |
| Care Home Manager | Click here to enter text. |

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| Next of kin or primary contact | Click here to enter text. |
| Relationship | Click here to enter text. |
| Address | Click here to enter text. |
| Tel No | Click here to enter text. |
| When can they be contacted e.g. day or night and for particular occasions such as accompanying a relative in ED/ XRAY etc. | Click here to enter text. |

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| GP: | Click here to enter text. |
| Address: | Click here to enter text. |
| Tel No: | Click here to enter text. |
| Other services/professionals involved with me: | Click here to enter text. |

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| Religion: | Click here to enter text. |
| Religious/spiritual needs: | Click here to enter text. |
| Ethnicity: | Click here to enter text. |

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| Allergies: |
| Click here to enter text. |
| **For MEDICATION please see accompanying copy of MAR Chart. Inhalers, GTN spray, eye drops, insulin and creams are with me if prescribed** |

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| How I take medication: (whole tablets, crushed tablets, injections, syrup) |
| Click here to enter text. |
| Is there a covert medication agreement? Yes No N/A |
| Click here to enter text. |

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| My current medical problems including any cognitive issues : |
| Click here to enter text. |

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| My relevant past medical history: |
| Click here to enter text. |

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| **What is ‘normal’ for me** |
| How I communicate/what language I speak | Click here to enter text. |
| Seeing/hearing: (problems with sight or hearing) | Click here to enter text. |
| How you know I am in pain | Click here to enter text. |
| Risk of choking, Dysphagia (eating, drinking and swallowing) | Click here to enter text. |
| Assistance required with eating and drinking (food cut up, aids) | Click here to enter text. |
| Support with moving and handling: (equipment I use such as pressure relief, walking aids etc) | Click here to enter a date. |
| How I keep safe: (Bed rails, support with challenging behaviour) | Click here to enter text. |
| Personal care needs: (Assistance with dressing, washing, etc) | Click here to enter text |
| How I use the toilet: (Continence aids, help to get to toilet) | Click here to enter text. |
| Sleeping: (sleep pattern/routine) | Click here to enter text. |
| My Skin integrity: (current issues/how often I need to be repositioned) | Click here to enter text. |

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| **My Likes and Dislikes** |

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| Likes: for example - what makes me less anxious, things I like to doe.g. watching TV, reading, music, routines.Dislikes: for example – is there anything that triggers a change in my behaviour? e.g. , medical interventions such as taking blood, noise, certain foods, strangers, physical touch. |
| Things I likePlease do this:Click here to enter text. |  | Things I don’t likeDon’t do this:Click here to enter text. |

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| Variance Sheet (to be completed by hospital staff) |
| Reference number | Details of change/s and signature |
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