SINGLE POINT OF ACCESS

Referrals to the Glenrothes and North East Fife Single Point of Access will ONLY be accepted where the Fife Single Shared Assessment two page referral and the Single Point of Access Addition Sheet have been completed or via the GP SCI Gateway referral system.

The Guidance document clearly states the various methods of referral.
SINGLE POINT OF ACCESS

SINGLE SHARED ASSESSMENT (SSA) REFERRAL

Additional Guidance:

- Please ensure that all areas are completed (ENTER INFORMATION CLEARLY).
- Please ensure that the patient's home telephone number is documented.

Number:

- CHI number **must** be documented in this box.

Reason for Referral:

Please indicate this clearly and include the patient's diagnosis.

Do not leave sections blank. Score section through if not applicable or state 'not known'. If there is nothing documented then staff will assume the question has not been asked.

Failure to fully complete the referral form and provide clear reasons for the referral may result in the referral being sent back to the referrer for completion, therefore delaying the referral pathway.
NAME, ADDRESS, ETC.
♦ Enter the name of organisation you represent opposite “Agency”, e.g. agencies are Primary Care Division, Acute Division, Social Work or Housing.
♦ Enter relevant number within organisation, e.g. Social Work Pin No., Housing Application, Tenant No. or Health CHI No.
♦ Enter name, address and telephone number (postcode must be recorded).
♦ Enter preferred name if given.
♦ Enter current address details, if different from permanent address, including telephone number.

♦ Tick relevant Gender box.
♦ Enter Date of Birth and Age.
♦ Enter Marital Status.

REligion
♦ Enter details of Religion

ETHNICITY
♦ A person’s ethnicity is the description they currently use to describe their identity, please specify from this list:
  White        White British
  White Irish  White Other
  Asian/British Asian Indian
                Pakistani
                Bangladeshi
                Other Asian Background
  Black/Black British Caribbean
                African
                Other Black Background
  Chinese
  Other Ethnic Groups Gypsy Traveller
                Other Ethnic Group

LIVING ARRANGEMENTS
♦ Tick the appropriate box where the person is currently situated.
♦ Record the number of other adults and children (state ages) in household.
♦ If in Hospital, enter details of Hospital, Ward No., Reason for Admission and Admission Date.
♦ If in Care Home, enter Name and Address of Care Home.
♦ Enter details of access arrangement, e.g. use back door, contact family members first, etc.
♦ If the person is homeless then a further assessment may be required – tick BOX 1 to identify action required.

COMMUNICATION
♦ Please note if there are communication difficulties.
♦ Enter details of communication support required, e.g. Interpreting Service, Fife Society for the Blind, Deaf Communication Service. Consideration may be given for a referral to the Speech & Language Team.
♦ Indicate if Independent Advocacy required, e.g. does the person need independent support to be able to communicate their views?
♦ Tick BOX 2 to identify action required.

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000
♦ Please state if anyone has been appointed under the Adults with Incapacity (Scotland) Act 2000 to make decisions concerning welfare and/or finance issues. Consideration may be given for referral to the Mental Health Officer Team.
♦ If yes, give name of person(s) appointed and appointments held.
♦ If this is not known, please tick BOX 3 to identify action required.

MENTAL HEALTH (SCOTLAND) ACT 2003
♦ If appropriate, ask the person if they are receiving care under the Mental Health Act or Care Programme Approach (CPA).
  If person is not willing to state this, or discuss question, please do not continue to pursue this with them at this time.
<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENCY:</td>
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<tr>
<td>NUMBER:</td>
<td></td>
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<tr>
<td>SURNAME</td>
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<tr>
<td>FORENAME</td>
<td></td>
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<tr>
<td>TITLE</td>
<td></td>
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<tr>
<td>PREFERRED NAME</td>
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<tr>
<td>ADDRESS</td>
<td></td>
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<td>POSTCODE</td>
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<tr>
<td>TEL NO. (INC STD)</td>
<td></td>
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<tr>
<td>MOBILE</td>
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<td>CURRENT ADDRESS (If different permanent address)</td>
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<tr>
<td>ADDRESS</td>
<td></td>
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<tr>
<td>POSTCODE</td>
<td></td>
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<tr>
<td>GENDER: MALE FEMALE</td>
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<tr>
<td>MARITAL STATUS</td>
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<tr>
<td>D.O.B.: AGE</td>
<td></td>
</tr>
<tr>
<td>ETHNICITY</td>
<td></td>
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<tr>
<td>FIRST LANGUAGE</td>
<td></td>
</tr>
<tr>
<td>PREFERRED LANGUAGE</td>
<td></td>
</tr>
<tr>
<td>AT HOME</td>
<td>LIVES ALONE YES ☐ NO ☐</td>
</tr>
<tr>
<td>NOS. IN HOUSEHOLD:</td>
<td>ADULTS ................... CHILDREN (+ Ages) ..................................</td>
</tr>
<tr>
<td>IN HOSPITAL</td>
<td>HOSPITAL NAME ..................... WARD NO. ..............................</td>
</tr>
<tr>
<td>REASON FOR ADMISSION</td>
<td>ADMISSION DATE .................................................................</td>
</tr>
<tr>
<td>CARE HOME</td>
<td>NAME .......................................................................................</td>
</tr>
<tr>
<td>HOMELESS</td>
<td>OTHER .....................................................................................</td>
</tr>
<tr>
<td>ACCESS ARRANGEMENTS</td>
<td></td>
</tr>
<tr>
<td>COMMUNICATION DIFFICULTIES Y/N If YES please specify</td>
<td></td>
</tr>
<tr>
<td>Type of Support Required</td>
<td></td>
</tr>
<tr>
<td>ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000:</td>
<td></td>
</tr>
<tr>
<td>HAS ANYONE BEEN APPOINTED RE WELFARE AND/OR FINANCE: YES ☐ NO ☐ DON'T KNOW ☐</td>
<td>Specify ..................................................................................</td>
</tr>
<tr>
<td>MENTAL HEALTH CARE AND TREATMENT (SCOTLAND) ACT 2003:</td>
<td>Specify Section of Act which applies ........................................</td>
</tr>
</tbody>
</table>

Page 2 – Basic Information/Referral
CONTACT DETAILS
♦ Enter details, where applicable, of Next of Kin, Emergency Contact or Named Person, G.P., Other and Contacts, noting whether they are a keyworker.

PERSON BEING REFERRED
Is the person being referred aware of referral
♦ Tick appropriate box if person is aware that referral/request being made.
♦ If not, contact can be made with referred person for consent OR further discussion depending on reason for referral.

REASON FOR REFERRAL
♦ Enter information given why referral is being made.
♦ Enter details of source of referral, relationship to the person being referred, e.g. self, family/friend, Social Work, Housing, Health, Education, Police, Voluntary Agency, anonymous or other. How was referral made. e.g. visit, telephone and contact details.

RISK ALERT
♦ Enter details of any known risk or potential risk to other people, e.g. person’s behaviour or pets and environment.
♦ Relevant facts should be recorded.
♦ Please tick BOX 4 to identify action required.

PERSON MAKING REFERRAL
♦ Enter details of person making referral.

PERSON TAKING REFERRAL
♦ Enter details of who has taken referral.
♦ Enter details of person/team who will receive referral for Single Shared Assessment. Please date when referring information. This needs to be actual date as this can differ from date referral taken.

REFERRED TO
♦ Please record details of either individual or service name where referral being directed. Please enter details of all people/services if more than one referral being sent.

REFERRAL OUTCOME
♦ To be completed by receiving Agency.
♦ Please tick relevant box regarding referral outcome. Please sign and date.
IS THE PERSON BEING REFERRED AWARE THAT THIS REQUEST HAS BEEN MADE?  YES ☐ NO ☐ ☐

If No, state reason

REASON FOR REFERRAL: (including relevant background information):
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

PERSON MAKING REFERRAL

CONTACT ADDRESS/TEL. NO.(incl. STD)

RELATIONSHIP

REFERRAL METHOD

DATE

PERSON TAKING REFERRAL

DESIGNATION

ADDRESS/TEL. NO.(incl. STD)

IF REFERRAL NOT ACTIONED, PLEASE STATE REASON

DATE

REFERRED TO

DESIGNATION/SERVICE

ADDRESS/TEL. NO.(incl. STD)

REFERRAL OUTCOME (Tick as required):

SINGLE SHARED ASSESSMENT ☐ SSA REASSESSMENT ☐ FAST TRACK (OT) ☐

INFORMATION PROVIDED ☐ NO FURTHER ACTION ☐

Signed …………………………… Designation …………………………… Date ………………….
SINGLE POINT OF ACCESS

ADDITION SHEET

MUST ACCOMPANY SINGLE SHARED ASSESSMENT REFERRAL

Patient Name: _________________________ CHI number: ___________________

☐ This referral will prevent a hospital admission
☐ This referral will assist in supported discharge
☐ This is a routine rehabilitation referral

Diagnosis/Present condition:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Past Medical History:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Social History (include Services involved e.g. Home Care):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Current Medication:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Recent Hospital or Rehabilitation Service involvement (if known):
____________________________________________________________________________

If you would like this patient referred to a particular Team/Service, please state:
____________________________________________________________________________

Hospital/Service: _________________________ Discharge Date (if known): ____________

Signature: _________________________ Designation: _________________________

Print Name: _________________________ Date: _________________________

SPOA Referral Guidance Issue I 19 July 2007
Originator: Lorna Mackenzie Project Manager 8 of 15 Review Date: 01 March 2008
MAIL REFERRALS

Internal or External referrals:

Complete:

- First two pages of Fife Single Shared Assessment (referral details)
- Single Point of Access Addition Sheet

Send to:

- Administrator for SPOA
  Ladybank Clinic
  Commercial Road
  LADYBANK
  KY15 7JS
SINGLE POINT OF ACCESS

TELEPHONE REFERRALS

Internal or External referrals:

Telephone: Administrator of Single Point of Access
01337 831796

Administrator will ask for essential patient information to be able to process the referral:

- Name
- DoB & CHI number
- Address
- Home telephone number
- Reason for referral
- Patient lives alone?
- GP
- Risk alert
- Patient aware of referral
- Patient's present condition
- Patient's past medical history
- Current medication
- Current Services (if known)
- Type of referral: Routine/Prevention of Admission/Supported Discharge
- Preferred rehabilitation service (if known)

The referrer will be required to follow up the telephone call by sending SSA Referral and the Addition Sheet to the SPOA Administrator by mail, fax, e-mail or SCI Gateway (see Guidance).
SINGLE POINT OF ACCESS

FAX REFERRALS

Internal or External referrals:

Complete:

- First two pages of Fife SSA (referral details)
- SPOA Addition Sheet
- Area FAX header (stating that the information you are sending is confidential).

Ensure the FAX machine's 'memory dial' has the SPOA details stored. If not, then please ensure this is carried out. This will reduce the risk of misdialing, complying with the 'safe haven' policy (external referrers will require to reference their area's policies).

It is good practice always to precede the FAX transmission by a telephone call to ensure the recipient will be available to receive the FAX and then for that receipt to be confirmed.

When patient identifiable information is transmitted, every effort must be made to transmit the clinical information separately from the personal details. Clinical information can be sent with a suitable identifier (e.g. CHI number) and the name and address conveyed by telephone.

Every effort must be made to transmit referrals within SPOA working hours (Mon – Fri 9.00 am – 5.00 pm). The office, however, will be locked outwith office hours ensuring information remains confidential.

SPOA: Fax Number: 01337 831709  Tel No: 01337 831796

Please refer to the NHS Fife 'Safe Haven' Policy on Holding and Transmission of Personal, Confidential and Patient Identifiable Information.
SINGLE POINT OF ACCESS

E-MAIL REFERRALS

NHS mail (nhs.net) is the only method by which personal identifiable information can be securely sent by e-mail.

Until all staff have an nhs.net address the following guidance is recommended.

Internal Referrals:

Personal identifiable information can be securely sent by e-mail to and from NHS Fife e-mail users i.e. nhs.net, fife-pct and faht users. If your address is one of these then you can refer to the SPOA securely by e-mail.

Complete on electronic format:

- First two pages of the Fife Single Shared Assessment (referral details)
- SPOA Addition Sheet
- The SSA Referral and Addition Sheet are required to be sent as 'attachments' to the following e-mail address:
  gnefspoa@nhs.net
- The SPOA Administrator will acknowledge receipt of your referral.

External Referrals:

If your e-mail address is nhs.net, gsx.gov.uk, gsi.gov.uk then you can refer to the SPOA securely by e-mail and should follow the above method.

If you do not have such an e-mail address then you must use another referral option.

Please adhere to the NHS Fife e-mail Policy
External referrers must refer to their own Policy and Guidance.

This Guidance has been approved by the Author of the NHS Fife E-mail Policy

SPOA Referral Guidance  Issue I  19 July 2007
Originator: Lorna Mackenzie Project Manager  12 of 15  Review Date: 01 March 2008
Glenrothes and North East Fife Community Health Partnership

SINGLE POINT OF ACCESS

GP ELECTRONIC REFERRAL FORMAT (SCI Gateway)

Referral to: Glenrothes and North East Fife SPOA will be a drop down option.

Urgency of Referral:

Please state whether the referral is:

- Prevention of admission
- Early supported discharge or
- Routine

Patient details: Please ensure that the patients’ CHI number and home telephone number are populated.

Clinical Information: Please ensure that the patients’ presenting complaint, reason for referral and past medical history are clearly documented.

Clinical Warnings: Please can you identify any potential risk factors that should be known to community staff e.g. pets, personal and environment.

Additional Relevant Information: Please state Social History (include Services involved e.g. Home Care), any recent Hospital or Rehabilitation Service involvement (if known). Please state preferred rehabilitation team service (if known).

Failure to populate all the relevant sections and provide clear reasons for referral may result in the referral being sent back to the referrer for completion, therefore delaying the referral pathway.

The SPOA Administrator will acknowledge receipt of your referral.
**REFERRAL LETTER**
**MEDICAL IN CONFIDENCE**

**REFERRAL TO**

<table>
<thead>
<tr>
<th>Ear, Nose &amp; Throat (ENT)</th>
<th>Consultant / receiving practitioner and/or specialty clinic</th>
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<tbody>
<tr>
<td>Fife General Referral</td>
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<table>
<thead>
<tr>
<th>Queen Margaret Hospital</th>
<th>Hospital and hospital address</th>
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<tbody>
<tr>
<td>Whitefield Road</td>
<td>Hospital unit no.</td>
</tr>
<tr>
<td>Dunfermline</td>
<td>F805H</td>
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<tr>
<td>KY12 0SU</td>
<td>Email address</td>
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**Urgency of referral**

Routine

**PATIENT DETAILS**

<table>
<thead>
<tr>
<th>Surname</th>
<th>Patient’s address</th>
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<table>
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<tr>
<th>Forename(s)</th>
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<table>
<thead>
<tr>
<th>Title</th>
<th>Contact number(s)</th>
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<tr>
<th>Date of birth</th>
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<th>CHI no.</th>
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</table>
CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Reason for referral
Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)
No medications recorded

Recent medication (Any medication issued within last 90 days not shown above)
No recent medications recorded

Clinical warnings

Lifestyle risks
Exercise status: Not Known

Smoking status        Alcohol consumption
Not Known             Units per day

? (not known)

Additional relevant information

Administrative Information
Referred By: Registered GP