POST FALL EMERGENCY SERVICES FORM

The blue section will be needed by the 999 call handler

The purple section will be needed by paramedics on arrival and the Emergency Department Team

The green section will be needed by the Emergency Department Team

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| --- | --- | --- | --- |
| Date of call |  | Time of call |  |
| Reason for 999 call |  |
| Patient name |  | Patient DOB |  |
| Property name and address |  | Property telephonenumber |  |
| Person(s) in charge |  |
| Next of kin (NOK) |  | NOK contactnumber |  |
| *(tick if informed)* |  |
| GP name and surgery |  | Surgery contactnumber |  |
| Has the patient seen a GP in the last 2 weeks? | *If yes, please state here the date of and reason for the consultation:* |
| **ASSESSMENT *(tick where appropriate)*** |
| Conscious and responding as usual |  | Less responsive than usual |  | Unresponsive or unconscious |  |
| No pain or discomfort |  | Slight discomfort |  | Pain and/or some discomfort |  |
| No apparent bruising or wounds, or signs of limb deformity or shortening/rotation of leg |  | Minor bruising or wounds but no sign of limb deformity or shortening/rotation of leg |  | Uncontrolled bleeding, limb deformity, extensiveswelling or bruising |  |
| Able to move limbs or mobilise as usual |  | Unable to move limbs as usual |  | Unable to mobilise as usual |  |
| Please note any clinical observations taken *(where possible)* | Time | : | : | : |
| Respiratory Rate |  |  |  |
| Oxygen Saturations |  |  |  |
| Heart Rate |  |  |  |
| Capillary Refill |  |  |  |
| Blood Pressure |  |  |  |
| Blood Glucose |  |  |  |
| Temperature |  |  |  |
| Indicate location of visible or suspected injury or complaint of pain/discomfort. | This body chart relates to any physical assessment |
| **B =** Bruise**P =** Pain**\*** **W =** Wound **S =** Swelling **F =** Fracture |
| **\***Pain score |  |
| Past medical history |  |
| Current medications *(please state if new medications started)* | *If on Parkinson’s/epilepsy medication, please send this with the patient, should they be conveyed, with the times the medication is due.* |
| Known drug allergies |  |
| Details of treatment given or actions taken by staff |  |
| Does the patient have a care plan in place? *(where applicable please provide brief details of its content)* | Treatment Escalation Plan (TEP) or ReSPECT form? |  |
| Do Not Attempt Resuscitation (DNAR) form? |  |
| ***NB****. An original copy of the document should travel with the patient where possible* | Advanced Decision to Refuse Treatment (ADRT) form? |  |
| *Other plans/additional details:* |
| Does the patient have a Lasting Power of Attorney (LPoA)? *(circle as appropriate and provide details)* | Health & welfare? | *Name of LPoA: Relationship to patient: Contact details:* |
| Property & financialaffairs? | *Name of LPoA:**Relationship to patient: Contact details:* |
| How does the patient normally mobilise? |  |
| How does the patient normally communicate? |  *Please include any known impairments such as VI* |
| What care does the patient need each day? |  |
| Is the patient known to be infectious?*(place tick in circle next to any that are applicable and provide additional details where required)* | Clostridium difficile (C-diff)  |  | MRSA  |  |
| Covid-19  |  | Norovirus  |  |
| Diarrhoea and/or vomiting  |  | Scabies |  |
| Escherichia coli (E-coli)  |  | Streptococci |  |
| Influenza  |  | Shingles |  |
| Measles |  | Tuberculosis (TB) |  |
| MERS |  |  |  |
| *Any other infectious condition/additional details:* |
| Record of property beingconveyed with the patient *(Please send an item that will help the patient to settle but is not irreplaceable should it be lost)* |  |
| Please provide details of anyone travelling with the patient*(If you are unable to send anyone, please consider asking a family member to meet them at the ED)* | *Name of person travelling: Relationship to patient: Contact details:* |
| Who should the ED team contact for further information / to provide updates? | *Name of person:* *Role within home:**Contact details:***Please ensure this phone number is monitored overnight as the resident may be returned out of office hours.** |
| Name of staff member completing form |  | Signature |  |