Somerset Partnership NHS
NHS Foundation Trust

PLANNED AMBULATORY CARE PATHWAY

Referring Organisation

Step 1: Does patient meet ambulatory care criteria?

- patient NOT for acute care
- age over 18 years
- must be able to be managed in a chair or bed for duration of treatment
- requires no more than one nurse to mobilise
- must be able to take own medication
- therapy can be given during unit hours and time slots

NO → Refer to secondary care / alternate service pathway

Yes ↓

Step 2: Complete the generic referral form (Appointment will not be booked until this completed in full)

- Consent the patient for treatment and provide information on treatment and ambulatory care unit.
- Forward referral form to ambulatory care unit (e-mail or fax)

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Step 3: Complete Treatment Specific Paperwork (e.g. Authorisation form for administration of medication / Treatment Specific Care Plan) (Appointment will not be booked until this completed in full)

- Complete in full and forward to ambulatory unit.
- A fax, or e-mail can be accepted for provisional booking but the original signed document will be required to administer any medication. Patients will be cancelled without the original signed authorisation to administer medications form.

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Step 4: Complete prescription / supply paperwork if required

- If treatment / therapy requested are **NOT** included in an agreed pathway and/or supplied by the ambulatory care unit, agree the treatment to be provided with the ambulatory care unit.
- Complete a prescription to supply the medication and obtain supply as required. Arrange for medicines to be provided to the ambulatory care unit in line with the patient appointment date.
- Complete paperwork to supply non medicine therapy required and obtain supplies via usual process. Arrange for supply to be provided to the ambulatory care unit in line with the appointment date.

Ambulatory Care Unit

Pre –Admission

Step 5: Check referral paperwork for completeness and accuracy and Rio updated

- ☐ referral form received and checked
- ☐ authorisation form to administer medicine for completeness and accuracy including dose and appropriateness (if required) received and checked
- ☐ administration details of IV therapy agreed and checked
- ☐ treatment supply confirmed
- ☐ Method for receipt of ORIGINAL SIGNED medication authorisation from agreed.

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Step 6: ☐ Provisional appointment booked for patient

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Step 7: Confirm appointment details with patient.

☐ The ORIGINALSIGNED authorisation form to administer medication received before a patient can be admitted to the service and receive medications.

Admission / discharge

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Step 8: Patient admitted to ambulatory care unit and treatment given

- ☐ Authorisation form to administer medication WITH ORRIGINAL SIGNATURE received and checked
- ☐ Somerset Partnership Care Plan and paperwork completed
- ☐ Patient information provided (on treatment and follow up)
- ☐ Discharge information sent to the GP, patient and follow up healthcare professional as requested in the referral or as per patient pathway.

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Step 9: Follow up

- Undertaken as agreed in patient pathway

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PLANNED AMBULATORY CARE CLINICS REFERAL FORM

Criteria

I confirm the patient meets the planned ambulatory care criteria (please tick)

☐ >18 yrs of age

☐ Can be managed in a chair/bed for the duration of the treatment

☐ Is able to take their own medication

☐ Requires no more than 1 nurse to mobilise

Patient Details

Title
Surname .....

Forename .....

Date of Birth ...../...../.....

Address .....

.....

Telephone Number: .....

NHS Number.....

Any special requirements e.g. interpreter? Yes ☐ No ☐

Details:

Registered GP name:

Surgery Address:

Telephone Number:

Fax Number:

E-mail:

Relevant Past Medical History (PMH):
(Surgery print out can be used)

Current regular / PRN / OTC medications:
(Surgery print out/ Summary care record can be used)

ALLERGIES:

Referral details

Referral to which ambulatory care clinic:

☐ **Frome** ☐ **Wiliton** ☐ **Shepton Mallet** ☐ **Bridgwater** ☐ **Kilkenny Crt** ☐ **Chard**

Referral for which service:

☐ Blood transfusion
☐ IV Iron. (Ferinject®)
☐ IV Iron (other)
☐ IV antibiotics
☐ Other agreed IV therapy
Details:

☐ ABPI
☐ Central line management
☐ Chest drains
☐ Taking bloods via central line
☐ Disconnect chemotherapy
☐ Urinary Catheterisation and agreed catheter care

☐ Wound care/dressings
☐ Complex dressings inc. VAC
☐ Larvae therapy
☐ Other agreed service
Details:

Date 1st appointment required:

Level of service requested for medications:

☐ Administration only

☐ Administration AND supply of medication/treatment
(Please refer to pathway agreement where available)

Referring Practitioner details:

Referring practitioner name(PRINTED)

Designation:
GMC number / other professional number:

Referring practitioner signature:

Date:

Contact e-mail:

Contact phone:
Contact Fax:

Referring from (please tick):

☐ GP practice. Practice name:.....
☐ GP practice based on specialist recommendation (please provide supporting paperwork with referral)
☐ Secondary care:
Organisation name: .....AND Clinic / speciality:.....

Consent:

☐ **I have provided information to the patient regarding the treatment / procedure**
☐ **I have documented informed consent gained from the patient**

Signature of referrer: ..... Date:.....

Printed name of referrer:.....