Suffolk Community Services
Community Matrons

REFERRAL TO COMMUNITY MATRONS
(Please email to Care Co-ordination Centre on suffolk.ccc@esneft.nhs.uk

The Community Matron Service provides nursing case management for patients with complex long term conditions and who are at high risk of future hospital admission and who would benefit from having their care co-ordinated and reviewed regularly.

(Please use the tab key or mouse to move to the next grey text block – please click to 'check' boxes)

Patient Details:	***GP Details:***
Name: DoB: Address: Postcode: Tel Nos: NHS No:	GP Name: Surgery: Tel No: Fax No:
Preferred first language if not English:	***Urgency: GREEN – non urgent***
Reason for referral (health problems and any specific care requests) **[*Outcomes - what do you/patient want to achieve*]**	
Past medical history and current medication (computer print-out if possible)	
Does the patient have a frailty score known? Y ☐ N ☐ *If yes please specify (mild, moderate, severe or Rockwood score 1-9):*	
Referrers Details:	
Name: Designation: Team:	Address: Tel No: Fax No:
Date of referral:	***Has patient agreed to the referral?*** ☐**YES** / **NO**☐

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Indicators for referral to the Community Matrons:

If you are in any doubt whether the patient/customer fully meets the referral criteria please contact the team who will be happy to discuss.

*The patient will have **3 long term conditions** and 2 or more of the following:*

- *3 or more admissions to hospital in last 6 months* ☐
- *3 or more A&E attendances last 6 months (especially for the same reasons)* ☐
- *2 or more falls in the past 2 months* ☐
- *Recent admission > 4wks duration* ☐
- *High user of GP services* ☐
- *Suffered a bereavement within the past year and are at risk of medical/social decline* ☐
- *People taking 5 or more medications* ☐

The Community Matrons will:

- Attempt telephone contact and/or send letter to arrange a date and time for an assessment visit.
- Aim to visit within 2 weeks to carry out an assessment.
- Assessment will be recorded on Systm1
- Remain in regular contact with patient as clinical needs require.
- Work in close co-ordination with GP in patients best interest.
- Discuss with GP when case-management is no longer needed and arrange return to normal care with patient.

Case management will include:

- Comprehensive assessment.
- Teaching self-management skills and confidence building.
- Long-term condition monitoring and exacerbation management.
- Medication advice and management.
- Carer support.
- Crisis intervention to prevent admission if possible.
- Referral to other services: LHCT, equipment, specialist nurses, social services for respite or personal care needs.