TO BE COMPLETED BY REFERRING TEAM

Affix patient sticker here

Hospital admission date: ____________________

Date of assessment: ____________________

Time of assessment: ____________________

Critical Care Referral Form

This form should be used to guide and record referral for critical care support. It is adapted from SBAR, and designed to support best practice in decision-making. It should not replace direct referrals and discussions.

Situation*:* *(reason for referral)*

Background: **Patient's medical history and evidence regarding ability to recover from critical illness** *(e.g: frailty score, trajectory of illness, physiological reserve, etc.)*

Patient's values and wishes: *(What is important to the patient about outcomes of their care?) Please note any ReSPECT form/ advance decision to refuse treatment.) Please document reasons if no information available.*

Please document source of information: *(patient, family member or someone close to patient, advance care plan etc)* ____________

____

Discussed with referring team consultant (name):____

Recommendation

- ☐ To obtain a review to consider admission to ICU/HDU for full or limited organ support
- ☐ To obtain a review but not necessarily to admit to ICU/HDU
- ☐ For assistance with a specific therapy to be delivered outside ICU *(Please specify)*______________ ____
- ☐ To obtain a review to plan care in the event of deterioration
- ☐ Other *(please specify)*____

Has the patient or a person close to them been given an information sheet regarding referral to intensive care? ☐

Discussed with ICU team member: Name:____

Role:______________________________ Date ____________________ time:__________

Name:____Signature: ________________________

Role:____GMC number: ______________________

This project was funded by the NIHR HS&DR programme (project number 13/10/14)
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