IRWAYS$_2$

IN HOSPITAL DETAILS

H3

Patient Name: _____ **Patient ID:** | | | | | | | | | |

COMPLETE THIS FORM FOR PATIENTS WHO HAVE CONSENTED UNDER OPTIONS A OR B

Patient address _____

GP address _____

Patient phone number _____

GP name _____

Can answer machine messages be left? *Yes* ☐ *No* ☐

GP phone number _____

Patient email address _____

Patient's preferred mode of contact for follow up questionnaires (tick all that apply)

Post ☐ *Phone* ☐ *Email/web* ☐

Please download GP letter and file in medical notes.

The GP letter will be sent to GP by the coordinating centre.

WARD MOVEMENTS/ LEVELS OF CARE

Please provide any ward movements/ level of care changes after initial discharge from ITU:

Destination codes: 1=Level 1, 2=Level 2, 3=Level 3, 4=Hospital discharge, 5=Patient died

	Admission/ transfer date and time	Level of care	Destination code
1	__ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)	*Level 1* (e.g. General) ☐ *Level 2* (e.g. HDU) ☐ *Level 3* (e.g. ITU) ☐	*Code* ☐
2	__ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)	*Level 1* (e.g. General) ☐ *Level 2* (e.g. HDU) ☐ *Level 3* (e.g. ITU) ☐	*Code* ☐
3	__ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)	*Level 1* (e.g. General) ☐ *Level 2* (e.g. HDU) ☐ *Level 3* (e.g. ITU) ☐	*Code* ☐
4	__ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)	*Level 1* (e.g. General) ☐ *Level 2* (e.g. HDU) ☐ *Level 3* (e.g. ITU) ☐	*Code* ☐
5	__ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)	*Level 1* (e.g. General) ☐ *Level 2* (e.g. HDU) ☐ *Level 3* (e.g. ITU) ☐	*Code* ☐

DISCHARGE DETAILS

Did patient survive to hospital discharge? *Yes* ☐ *No* ☐

If **NO**, date/time of death __ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)

If **YES:**

Date/time of discharge __ __/__ __/__ __ __ __ (d d m m y y y y) ____ ____ : ____ ____ (24 hr clock)

Discharge destination *Home* ☐ *Other Hospital* ☐ *If other hospital, please provide hospital name* _____

Residential/ Nursing home ☐ *Rehabilitation facility* ☐ *Other* ☐ *If other, details* _____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: ___/__ __/__ __ __ __

** Names must appear on the site signature & delegation log*