|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hospice Use Only** | **Date received:** |  | **Ref No:** |  |

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| **REFERRAL TO COMMUNITY AND INPATIENT UNIT SPECIALIST PALLIATIVE CARE SERVICES** |
| **Patient Name** |       | **Date of Birth** |       |
| **H&C No** |       | **Sex** |       |
| **Address** |       | **Marital Status** |       |
|  |       | **Ethnic Origin** |       |
| **Post Code** |       | **Religion** |       |
| **Tel No** |       | **Occupation** |       |
| **Mobile No** |       | **No of Dependents (under 18 years)** |       |
| **Next of Kin** | **Main Carer (if different from Next of Kin)** |
| **Name** |       | **Name** |       |
| **Address** |       | **Address** |       |
|  |       |  |       |
| **Post Code** |       | **Post Code** |       |
| **Tel No** |       | **Tel No** |       |
| **Mobile No** |       | **Mobile No** |       |
| **Relationship to Patient** | Wife | **Relationship to Patient**  |       |
| **Referrer** | **GP** |
| **Name of Referrer** |       | **Name of GP** |       |
| **Address** |       | **Address** |       |
|  |       |  |       |
| **Post Code** |       | **Post Code** |       |
| **Tel No** |       | **Tel No** |       |
| **District Nurse** | **Other Healthcare Professional** |
| **Name of DN** |       | **Consultant** |       |
| **Address** |       | **Palliative Care Nurse Specialist**  |       |
|  |       | **Palliative Medicine Consultant** |       |
| **Post Code** |       | **Social Worker** |       |
| **Tel No** |       | **Other**  |       |
| **ELCOS Status**  |
| **A = may be years** |[ ]  **B = Could be last year** |[ ]  **C = Possibly months/weeks** |[ ]  **D = Probably last few days** |[ ]
| **Reason for Referral (please select )** | **Service(s) Requested (please select)** |
| **Symptom Management** |[ ]  **Inpatient Unit Admission** |[ ]
| **Rehabilitation** |[ ]  **Day Therapy**  |[ ]
| **End of Life Support** |[ ]  **Outpatient Clinic** |[ ]
|  |  | **Community Palliative Care Nurse Specialist**  |[ ]
| **Other (please specify)** |       | **Other (please specify)** |       |
| **The patient is currently (please select one option)** |
| **At Home** |[ ]  **At Hospital** |[ ]
| **At Nursing Home**  |[ ]  **Other (please specify)** |[ ]
| **Patient Diagnosis**  |
| **Primary Diagnosis** **and date** |   |
| **Secondary Diagnosis** **and date** |       |
| **Histology (if known)** |       |
| **Current problems**  | **(enter details of unresolved complex physical, social, psychological and spiritual symptoms including concerns affecting carer/family, give details of what interventions you have trialled)** |
|  |   |
| **Treatments to date and further treatment planned**  | **(enter details of Consultant and hospital for all treatments)** |
|  |       |
| **Additional Information (e.g. details of results from previous scans, x-rays, blood tests, etc)**  |
|   |
| **Past Medical History**  |
|       |
| **Medication** |
| **Current medication as per discharge letter (obligatory)** |[ ]  **Syringe Pump** |       |
| **Known Allergies****(enter details)** |       |
| **Mobility (please select all that are appropriate)** | **Mobile** |[ ]  **Mobile with difficulty (stiffness, pain)** |[ ]
|  | **Mobile with assistance, equipment or aids** |[ ]  **Immobile** |[ ]
| **Oxygen Therapy** **(enter details)** |       |
| **Nutritional Therapy** **(please select all that are appropriate)** | **Oral** |[ ]  **PEG** |[ ]  **NG** |[ ]
|  | **Any feeding difficulties?** |       |
| **Infection Status****e.g. MRSA, C.Diff, Pseudomonas** **(enter details)** |       |
| **Advance Care Plan** |
| **Has an Advance Care Plan been completed? (if yes, please forward details)** | **Yes** |[ ]  **No** |[ ]  **N/A** |[ ]
| **Preferred Place of Care** |
| **Please state Patient’s preferred place of care** |       |
| **Date** |       |
| **CPR Status** |
| **Has CPR Status been discussed with the patient?** | **Yes** |[ ]  **No** |[ ]   |
| **Current Status (please select)** | **DNACPR** |[ ]  **For CPR** |[ ]  **Not Known**  |[ ]
| **Has GP been notified of status?**  | **Yes** |[ ]  **No** |[ ]   |
| **Care Package**  |
| **Is there a care package in place?**  | **Yes** |[ ]  **No** |[ ]  **N/A** |[ ]
| **If you have answered Yes to the above question, please enter details**  |       |
| **Communication** |
| **Is the patient experiencing communication difficulties? Please enter details including if an interpreter is required.** |       |

|  |  |
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| **Patient Insight** | **Next of Kin/Main Carer Insight** |
| **Has the patient agreed to this referral?** | **Yes** |[ ]  **No** |[ ]  **Is the NOK/Main Carer aware of the referral?** | **Yes**  |[ ]  **No** |[ ]
| **Is the patient aware of their diagnosis?** | **Yes** |[ ]  **No** |[ ]  **Is the NOK/Main Carer aware of the patient’s diagnosis?** | **Yes** |[ ]  **No** |[ ]
| **If No, please explain why the patient is not aware of their diagnosis.** |       | **If No, please explain why NOK/Main Carer is not aware of the diagnosis.** |       |
| **Has prognosis been discussed with the patient?** | **Yes** |[ ]  **No** |[ ]  **Has prognosis been discussed with NOK/Main Carer?** | **Yes** |[ ]  **No** |[ ]
| **If No, please explain why the prognosis has not been discussed.** |       | **If No, please explain why the prognosis has not been discussed.**  |       |

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| **Submission** |
| **Has the Patient’s GP been made aware of this referral by the Referrer (Community only)?** | **Yes** |[ ]  **No** |[ ]
| **Please confirm name of GP contacted and date of call** | **Insert name of GP** | **Date** |       |
| **Authorisation** |
| **Please confirm that you have reviewed this form and all relevant information has been completed** **(please insert your name as your signature)** | **Signature of Referrer** | **Date** |       |
| **Designation of Referrer**  |       |

**PLEASE RETURN THIS FORM TO THE LOCAL SPECIALIST PALLIATIVE CARE SERVICE**