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| **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** |  | | | | | | | | **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**