**Referral Form - Specialist Palliative Care Services**

**(Please complete as thoroughly as possible or the initial assessment may be delayed)**

**FOR URGENT REFERRALS FOR ALL SERVICES PLEASE RING 01904 777770**

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| **Service Required** Pleaseemail completed form to: [**SLEHO.spcreferrals@nhs.net**](mailto:SLEHO.spcreferrals@nhs.net) | | | | | | | | |
| **Community Palliative Care Team**   **Inpatient Unit**   **Hospice@Home**  (Referral Criteria: [click here](https://www.stleonardshospice.org.uk/Professionals/Referral-Information-(1))) (Referral Criteria: [click here](https://www.stleonardshospice.org.uk/Professionals/Referral-Information-(1)))  **Urgent  Non Urgent  Date of referral:** | | | | | | | | |
| **Patient Details (Please print if handwritten)** | | | | | | | | |
| NHS No: | | Hospital No | | | Title: | | | DOB: |
| Surname: | | First Name: | | | Preferred Name: | | | Marital Status: |
| Address | | | | | | | | Postcode: |
| Tel: | | | | | Mobile: | | | |
| Current Location if not at home address: | | | | | | | | |
| Occupation: | | | | | Lives alone? Y  N | | | |
| Please specify any potential risk to a lone worker: | | | | | | | | |
| **Next of kin / Main Carer Details** | | | | | | | | |
| Full Name: | | | | Relationship: | | | | |
| Address: (if different from above): | | | | | | | Postcode: | |
| Tel: | | | Mob: | | | | | |
| **Referrer Details** | | | | | | | | |
| Name: | | | | | | Role: | | |
| Work base: | | | | | | Tel: | | |
| **COVID 19** | Is the patient/NOK displaying COVID symptoms Y  N | | | | | | | |

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| --- | --- | --- | --- | --- |
| **Disease Status** | | | | |
| Diagnosis and extent of disease (including date of diagnosis): | | | | |
| Current/Planned Treatments: | | | | |
| Phase of illness: | Stable  Patient problems and symptoms are adequately controlled by the existing plan of care. | Unstable  An urgent change in the plan of care or emergency treatment is required because they are experiencing a new problem that was not anticipated in the existing care plan or a rapid increase in the severity of a current problem. | Deteriorating  The patient’s overall function is declining and they are experiencing anticipated and gradual worsening of existing problems. | Dying  Death is likely within days to short weeks |
| Has DS1500 been applied for? Y  N | | | | |
| Is patient fast tracked Y  N  Care package provider: | | | | |

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| Responsible Authors: Sarah Wilcox, Dan Cottingham | | Responsible Professionals: Sarah Wilcox, Kath Sartain | |

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| --- |
| **Reason for Referral** – please circle most appropriate |
| **Symptom management Terminal care**  **Telephone Support** (CNS)  **Crisis management** (H@H) **Awaiting hospice Bed** (H@H) **OOH support** (H@H)  **Discharge support/meet & greet** (H@H) **Awaiting care package/increase** (H@H)  Please outline the main Physical/Psychological/Social/ Spiritual Issues: |
| **Consent agreed for referral?** **Y  N**  **Please note that referrals will not be accepted unless the patient or main carer has consented to the referral** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Professionals Involved** | | | |
| Consultant Name: | Hospital: | | Tel: |
| Usual GP: | Practice: | | Tel: |
| Other: | | | Tel: |
| Known to District Nurse? Y  N  Known to Social Services? Y  N  **Ensure District Nursing Team is informed of this referral via SPA on 01904 721200** | | | |
| **Advance Care Planning** | | | |
| Ceiling of care discussed? Y  N  For escalation Not for escalation | | | |
| DNA CPR Status in place? Y  N | | | |
| Preferred Place of Care: | | Preferred Place of Death: | |
| Are anticipatory drugs for end of life care in place? Y  N | | | |
| Has the patient got a written Advance Care Plan? Y  N  Please provide details: | | | |
| **Medications** | | | |
| For GP and community referrals, please attach a **brief** computer summary of the patient’s medication history  Is a syringe drive in situ Y  N  Contents:- | | | |
| **For In patient unit admissions** | | | |
| Does the patient need a side room for infection control purposes? (eg clostridium difficile, MRSA infection).  Please give details: | | | |
| Does the patient have any specialist equipment need? (eg. high flow oxygen, hoist, bariatric bed, intrathecal pump, non-invasive ventilation, PEG feeding etc).  Please give details: | | | |
| Does the patient require any mobility aids? (eg stick, frame, wheelchair, hoist) | | | |
| Other significant co-existing condition (include cognitive, sensory, hearing impairment, language barrier): | | | |