**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**

|  |
| --- |
| **Service Required** Pleaseemail completed form to: **SLEHO.spcreferrals@nhs.net** |
| **Community Palliative Care Team**  [ ]  **Inpatient Unit**  [ ]  **Hospice@Home**  [ ] (Referral Criteria: [click here](https://www.stleonardshospice.org.uk/Professionals/Referral-Information-%281%29)) (Referral Criteria: [click here](https://www.stleonardshospice.org.uk/Professionals/Referral-Information-%281%29))**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 [ ]  |

|  |
| --- |
| **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: |

|  |  |  |
| --- | --- | --- |
| Version: 6.0 | Date Published: 07.07.20 | Date of review: TBC |
| Responsible Authors: Sarah Wilcox, Dan Cottingham | Responsible Professionals: Sarah Wilcox, Kath Sartain |

**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**

|  |
| --- |
| **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 historyIs 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):       |