St Leonard's Hospice
Caring for Local People

York Teaching Hospital NHS
NHS Foundation Trust

St Leonard's Hospice@Home

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 Please email completed form to: SLEHO.spcreferrals@nhs.net			
Community Palliative Care Team ☐ (Referral Criteria: click here) **Urgent** ☐ **Non Urgent** ☐	**Inpatient Unit** ☐	**Hospice@Home** ☐ (Referral Criteria: click here) **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:				

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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 ☐ **Ensure District Nursing Team is informed of this referral via SPA on 01904 721200**	Known to Social Services? Y ☐ N ☐	
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):		