Specialist Palliative Care Referral Form

Send this form by NHS secure email

Date referral received:
Time received:

Phyllis Tuckwell Hospice Care ☐ Tel: 01252 729440 PTH.adviceandreferral@nhs.net	**Princess Alice Hospice at Home Team** ☐ Tel: 01372 461804 SDCCG.clinicaladminpah@nhs.net	**Macmillan Community Team** ☐ Tel: 01730 811121 SC-TR.MidhurstMacmillan@nhs.net
Woking Hospice, Woking ☐ Tel: 01483 881750 wokinghospice.referrals@nhs.net	**Sam Beare Community Team, Weybridge** ☐ Tel: 01932 598385 sambearehospice.referrals@nhs.net	**St Catherine's Hospice, Crawley** ☐ Tel: 01293 447333 stcatherineshospice.admin@nhs.net

Is the referral urgent due to rapidly changing needs? If 'Yes' phone the appropriate team for advice /assessment	**Yes** ☐	**No** ☐

The patient consented to this referral/best interest decision has been made? Yes ☐

The referring clinician has informed the patient that their GP notes will be shared with PTHC (PTHC patients only) Yes ☐

If patient lacks capacity to consent, has their relevant other been informed? Yes ☐ **No** ☐ (confirm details)

Please send copies of any relevant recent correspondence to assist responsive assessment e.g. consultant clinic letters, discharge summary and GP patient summary plus CPR status if known.

ESSENTIAL DETAILS FOR PERSON BEING REFERRED

Surname			Date of birth			
First name			NHS number			
Marital Status	Married ☐	Single ☐	Civil partnership ☐	Cohabiting ☐	Widowed ☐	Divorced ☐	Separated ☐
Known as					Male ☐ Female ☐	
Address and post code					Does the person live alone?	**Key Safe No.**
			Email			
Telephone number			Mobile number			

Next of Kin/Patient representative		**tick if LPA** ☐	**Main Carer (if different)**		
Surname		Address if different to patient	Surname		Address if different to patient
First Name			First Name		
Telephone			Telephone		
Email			Email		
Relationship to patient			Relationship to patient		

Patient's ethnic origin and religion

White	White – British ☐	White – Irish ☐	Black or Black British	African ☐ / Caribbean ☐	Asian or Asian British	Indian ☐ / Pakistani ☐
	White – other ☐			White and Black Caribbean ☐		Bangladeshi ☐
	Any other mixed ☐			White and Black African ☐		White and Asian ☐
Other	Chinese ☐ / Other ☐	Not stated ☐		Other Black/ African/ Caribbean ☐		Any other Asian background ☐
Religion				First language		

General Practitioner		**Community Nursing Services**	
Name		DN team	
Surgery		DN base tel. no.	
Telephone		DN mobile no.	
Secure nhs.net email		Secure nhs.net email	
GP aware of referral:	Yes ☐ No ☐ **If "No" please inform GP**	Out of hours DN numbers	

Community professional involved with patient's care		**If in hospital, please complete the following:**			
		Name of hospital		Hospital number	
Name		Ward		**Date of discharge:**	
Role		Direct ward telephone		Place of discharge:	
Based at				Is the patient being discharged home to die? Yes ☐ No ☐	
Telephone		Consultant		Is Hospital Palliative Care Team involved? Yes ☐ No ☐	

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Patient name		Date of birth		NHS number	

CLINICAL REFERRAL INFORMATION (please attach GP summary and details of current medication	
Is the patient living with an advanced or terminal illness? Yes ☐ No ☐	
Initial contact	The patient is able to attend an outpatient setting ☐
	The patient can only be seen at home (requires considerable assistance, or in bed >50% of the time). For Care at Home assessment. ☐
	The patient requires inpatient admission for symptom management or terminal care ☐

Patient's main problems/needs (please add details explaining reason for referral).
Highlight any oxygen needs, moving and handling or skin integrity concerns.

1.
2.
3.
4.
5.
6.

Diagnosis and relevant clinical history | Past medical & psychiatric history | Additional relevant information (psychosocial/spiritual)

Has patient been told diagnosis?	Yes ☐	No ☐	Is the carer aware of patient's diagnosis?	Yes ☐	No ☐
Does the patient discuss the illness freely?	Yes ☐	No ☐	Does the carer discuss the illness freely?	Yes ☐	No ☐

Phase of illness		Does patient have any of the following?	Yes	No	The patient is currently	
Stable ☐	Unstable ☐	PACE document	☐	☐	At home	☐
		Advance Care Plan	☐	☐	In hospital (specify below)	☐
Deteriorating ☐	Dying ☐	Other care/ management plan eg. ReSPECT, DNACPR	☐	☐	Other care setting (state where)	☐
Preferred place of care:		Resuscitation status (specify)				

Communication Does the patient have problems with:	Hearing ☐	Sight ☐	Speech ☐
Does the patient have cognitive impairment? Yes ☐ No ☐	Patient conscious ☐	Semi-conscious ☐	Unconscious ☐

Known concerns or risks	Yes	No	Tick box and add details
Are there any known **allergies?**			
Are there any lone worker concerns?			

Any current or previous safeguarding concerns?

Relevant family member/ main carer information including any potential risks

Please ensure the patient is aware information will be held on computer according to the Data Protection Act and will be shared with external healthcare professionals on a need to know basis

Referred by (print name) ______________________ Date of referral ______________________

Work base ______________________ Contact telephone ______________________

Job title