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| **Specialist Palliative Care Referral Form** | Date referral received:  |
| **Send this form by NHS secure email**  | 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.**  |

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| **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 |  |

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| **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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| **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 |  |