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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](mailto: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](mailto: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 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |