

PATIENT REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE Private and Confidential

Please **tick** service you are referring to:

- Hospice @ Home service
- Marie Curie planned over night service

Please **tick** reason you are referring:

- Symptom Control
- Care at the End of Life
- Advice and Support
- Carer Support

How soon is this service needed?

- Urgent- Telephone to discuss
- Contact within 2 working days
- Routine

PATIENT DETAILS

Name:..... Preferred name:.....
 D.O.B:..... NHS No:..... Postcode:..... Tel:.....
 Address:.....
 Current Location: Home Hospital If hospital, ward:.....
 Patient consent to referral Relevant family aware of referral Lives alone Yes No

REFERRING PERSON

Date of Referral:

Name:..... Designation:.....
 Phone:..... Address:.....

NEXT OF KIN/MAIN CARER

Name:..... Relationship:..... Phone:.....
 Address:..... Lasting Power of Attorney Personal welfare & Health

GP aware of referral GP name:..... Practice address:.....

Barriers to communication e.g. hearing loss, confusion:

Is there concern about this patient having the mental capacity for complex decision making? Yes No

Is there an active safeguarding concern with this patient? Yes No If yes please notify Safeguarding Concerns Manager

Contact Issues (share any information regarding contacting patient, access to property and lone worker risk)

Patent Religion: Ethnicity: Occupation:

PRIMARY PALLIATIVE DIAGNOSIS (include details and dates):.....

Other medical history:

Patient and family understanding of disease/prognosis:

Allergies:

Please attach supporting information (e.g. clinic letters, medication list)

Patient Name:..... NHS Number:.....

Patient is: Stable Unstable Deteriorating Dying

PROFESSIONALS INVOLVED		
Professional	Name	Location and tel
Consultant		
Specialist Nurse		
District Nurse		
Other		

Specialist Palliative Care Needs/Reason for referral

Please state as fully as possible the main problems that have led to the request for specialist palliative care. Include relevant information on physical symptoms, carers' needs, psycho-social/spiritual issues and difficult ethical needs as appropriate.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

What is the expectation for the patient and family of the team's involvement?

.....

.....

Additional Information (Please add any other concerns or issues relevant to the referral)

Recent /current infection? Yes No If yes please give details and test results/treatments

.....

On Oxygen therapy? Yes No Cylinder/Concentrator (please delete as applicable)

Patient has: DNACPR PalCall Anticipatory Drugs Last Days Care Plan GSF/EoL Register

NHS Fast Track/Continuing Health Care Funding DS1500 ACP

Preferred place of care specify..... Preferred place of death specify.....

Has patient consented to share information on their electronic record with the SPC service? Yes No

(the service will be unable to see any electronic information without this consent)

Any other information.....

.....

.....

FAX TO: 01723 506113

If the line is busy or you are unable to transmit your fax successfully, please fax to our alternate number, 01723 821620.