Saint Catherine's
Caring for you at Hospice and Home

Hospice @ Home
delivered in
partnership with
Marie Curie

Care and support through terminal illness | Marie Curie

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.