**Guidance on our services available at:**

[**www.saintcatherines.org.uk/referrals**](https://www.saintcatherines.org.uk/referrals)

Click or tap to enter a date.

**Incomplete forms will be returned to referrer**

**Section 1: Details of Person being referred: Date of Referral:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name:** | Click or tap here to enter text. | | **Address:** | Click or tap here to enter text. | |
| **Surname:** | Click or tap here to enter text. | |  |  | |
| **Preferred name:** | Click or tap here to enter text. | | **Postcode:** | Click or tap here to enter text. | |
| **DOB:** | Click or tap to enter a date. | | **Telephone:** | Click or tap here to enter text. | |
| **NHS Number:** | Click or tap here to enter text. | | **Barriers to communication:** | Click or tap here to enter text. | |
| **Gender:** | Click or tap here to enter text. | |  |  | |
| **Ethnicity:** | Click or tap here to enter text. | | **Religion:** | Click or tap here to enter text. | |
| **Current location:** | Home  Hospital  Care Home | | **If hospital, ward:** | Click or tap here to enter text. | |
| **Lives alone?** | Yes  No | | **Relevant family aware of referral?** | | Yes  No |
| **Is there a concern about this patient having the mental capacity for complex decision making?** | | | | | Yes  No |
| **Is there a lasting power of attorney for personal welfare and health?** | | | | | Yes  No |
| **If yes, please provide details:** | | Click or tap here to enter text. | | | |
| **Is there an active safeguarding concern with this patient?**  **If yes, please attach relevant details/documentation.** | | | | | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Name:** | Click or tap here to enter text. | **Surgery:** | Click or tap here to enter text. |
| **GP aware of Referral?** Yes  No | |  |

**Next of Kin/ Main Carer**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | Click or tap here to enter text. | **Relationship** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. | **Phone** | Click or tap here to enter text. |
| **Mobile** | Click or tap here to enter text. |

**Referring Person**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | Click or tap here to enter text. | **Role:** | Click or tap here to enter text. |
| **Organisation:** | Click or tap here to enter text. | **Contact Details:** | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please tick the service(s) you are referring to:** | | | |
| In-Patient Unit  IPU Nurse Led Bed  Hospice at Home  Marie Curie overnight service  CNS Palliative Neurology  CNS Community Palliative Care  Consultant Clinic  Wellbeing Centre Full Day  **Please complete sections 1 and 2** | | **Wellbeing Centre MDT Clinics**  **(tick only professionals whose assessment is required):**  Nurse  Doctor  Physiotherapy  Complementary Therapy  Social Work  **Please complete sections 1 and 2** | Lymphoedema Clinic |
| **Please complete sections 1 and 3** |
| Specialist Palliative Care Counselling  Bereavement Support |
| **Please complete sections 1 and 4** |
| **How soon is this service needed?** | Urgent  Routine | | |

**Section 2: Additional Referral Information**

For referrals to Lymphoedema Outpatient Clinic, Specialist Palliative Care Counselling or Bereavement Support, please **do not** complete this section. Please skip to section 3 or 4 as appropriate.

|  |  |
| --- | --- |
| **Primary Palliative Diagnosis: (include details and dates):** | Click or tap here to enter text. |
| **Relevant Past Medical History:** | Click or tap here to enter text. |
| **Patient and Family understanding of disease/prognosis:** | Click or tap here to enter text. |
| **Current medications:** | Click or tap here to enter text. |
| **Allergies:** | Click or tap here to enter text. |
| **Specialist Palliative Care Needs/Reason for Referral:**  (please provide as much detail as possible to assist triage) | Click or tap here to enter text. |
| **Patient and family expectations of the team’s involvement?** | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **On oxygen therapy?**  **If yes, please state:** | Yes  No  Cylinder  Concentrator | **Patient has:**  DNACPR  Anticipatory Drugs  Last Days Care Plan  Gold Standards Framework/End of Life Register  NHS Fast Track/Continuing Health Care Funding  DS1500  Advance Care Plan (ACP)  Advance Decision to Refuse Treatment (ADRT) | |
| **Preferred place of care known?**  **(if yes, please specify):** | Yes  No |
| **Preferred place of death known?**  **(if yes, please specify):** | Yes  No |
| **Can the patient get in and out of their house independently?** | Yes  No | **How does the patient mobilise?**  Please detail any recent falls or falls risks below. | Walking aids (please specify):  Click or tap here to enter text.  Wheelchair  Other (please specify):  Click or tap here to enter text. |
| **If attending Wellbeing, outpatients or IPU will transport be required?** | Yes  No |
| **Any other information:**  (please detail current infections, falls risks etc.) | Click or tap here to enter text. | | |

**Section 3: Additional Referral Information – Lymphoedema Clinic ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Weight** |  |  |  |
| If BMI > 40, has the patient been referred to a dietician? | Yes  No | Chair bound? | Yes  No |
| Can they attend the clinic? | Yes  No | Able to transfer? | Yes  No |
| Is transport required? | Yes  No | Will the patient be able to apply & remove compression hosiery? | Yes  No |
|  |  | If not, is social help in place if required? | Yes  No |

|  |  |
| --- | --- |
| **Details of cancer diagnosis causing lymphoedema:**  (with relevant dates) | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Past Medical History (tick all relevant boxes):** | |  | |
| DVT (within the last 6 months)  Heart Failure  Hypertension  SVC Obstruction  Cellulitis  Lymphorrhoea (wet legs)  Obesity | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | Diabetes  Chronic skin disorder  Renal failure  Arthritis  Hemiplegia  Venous disease | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No |
| **If yes, please provide details (with dates if known):** | Click or tap here to enter text. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **History of swelling/onset/limb(s) affected:** | Click or tap here to enter text. | | |
| **Other Areas Affected:**  Digits  Head and Neck  Trunk  Breast  Genitals | | **Skin:**  Fragile  Broken/ulcerated  Taut/shiny  Thickened  Limb weeping | Tissue is non-pitting & fibrotic  Limb distorted shape  Pain  Recurrent infection |
| **Evidence of venous or arterial insufficiency?** | Yes  No | **If yes, give details:** (please provide ABPI and full assessment)  Click or tap here to enter text. | |
| **Please attach current care plan and wound assessment if active ulcers or wounds present.** | | | |
| **Investigations:**  (Has the patient had recent investigations into their swelling? If so, please attach copies of recent blood tests, scans, cardiac echo etc) | | Click or tap here to enter text. | |
| **Current infection:**  **(MRSA/C-diff etc)** | Yes  No | **If yes, please specify:** | Click or tap here to enter text. |
| **Last wound swab result:**  (if applicable) | Click or tap here to enter text. | | **Date:** Click or tap to enter a date. |

**Section 4: Additional Referral Information – Specialist Palliative Care Counselling/Bereavement Support ONLY**

|  |  |  |
| --- | --- | --- |
| **Who is this referral for? (please tick one box)** | | |
| Patient receiving Palliative Care  **(skip to part 2)** | Relative/Carer of Patient receiving Palliative Care  **(complete parts 1a and 2)** | Relative/Carer – Bereavement Support  **(complete parts 1b and 2)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Part 1a: Details of Patient receiving Palliative Care** | | **Part 1b: Details of Person Deceased** | |
| **Name:** | Click or tap here to enter text. | **Name:** | Click or tap here to enter text. |
| **Relationship to person being referred:** | Click or tap here to enter text. | **Relationship to person being referred:** | Click or tap here to enter text. |
| **Diagnosis:** | Click or tap here to enter text. | **Date of Death (MM/YYYY):** | Click or tap to enter a date. |
| **Address (if different from previous page):** | Click or tap here to enter text. | **Cause of Death:** | Click or tap here to enter text. |

**Part 2:**

|  |  |
| --- | --- |
| **Reason for Referral:** | Click or tap here to enter text. |
| **Home Visits** | *We have limited capacity to offer home visits. Video conferencing can be offered, using an iPad on loan to the patient or family member/carer. This is very simple to operate and uses Facetime.*  Home visit required: Yes  No  If a home visit is definitely required, please state the reason:  Click or tap here to enter text. |
| **Details of other services involved:** | Click or tap here to enter text. |
| **Past mental health difficulties:** | Click or tap here to enter text. |
| **Psychiatric medication:** | Click or tap here to enter text. |
| **Known Risks:**  (to self, others or from home environment): | Click or tap here to enter text. |
| **Any Other Details:** | Click or tap here to enter text. |