**Guidance on our services available at:**

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

**Incomplete forms may result in delayed assessment.**

|  |
| --- |
| **Please tick the service(s) you are referring to:**Please [Click here](https://www.saintcatherines.org.uk/referrals/) to see our website for more information about the services we offer. Referrals will be triaged to the appropriate service and prioritised according to need depending on the information provided |
| **Inpatient Unit**[ ]  In-Patient Unit [ ]  Nurse Led Bed**Please complete section 1***Please inform Saint Catherine’s if requiring specialist equipment (e.g. bariatric bed, lateral turning system, specialist seating) to avoid delayed admission* | **Community Specialist Palliative Care:**[ ]  SPC Clinical Nurse Specialist[ ]  SPC Medical [ ]  SPC Social Work[ ]  Breathlessness Clinic**Please complete section 1***Initial assessment may be redirected to an alternative member of the MDT based on the information provided* | **Supportive Care services:** |
| [ ]  Wellbeing Services**Please complete section 1** |
| [ ]  Lymphoedema Clinic**Please complete sections 1 and 2** |
| [ ]  Counselling[ ]  Bereavement Support |
| **Please complete sections 1 and 3** |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name:** |  | **Current Address:** |  |  |
| **Known As:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DoB:** |  | **Telephone:** |  |  |
| **GP Surgery:** |  | **NHS Number:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current location:**  | Home [ ]  Care Home [ ]  Hospital [ ]  Other | **Specify Ward:** |  |
| **Next of kin:** |  | **Relationship:**  |  | **Tel:**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Who should we contact to arrange assessment?**  |  **Patient** [ ]  **NOK** [ ]  **Other** [ ]  | **Lives alone?** | Yes [ ]  No [ ]  |
| **Preferred initial contact (Name & telephone):** |  |
| **Is there concern about mental capacity for complex decision making?** (Add details below) | Yes [ ]  No [ ]  |
| **Is there a lasting power of attorney for personal welfare and health?** | Yes [ ]  No [ ]  |
| **Do they need ambulance transport? (Inpatient Unit referrals only)** | Yes [ ]  No [ ]  |

|  |  |  |
| --- | --- | --- |
| **Barriers to communication?** | Yes [ ]  No [ ]  | Details:  |
| **Is there an active safeguarding concern?** (Please attach relevant details/documentation) | Yes [ ]  No [ ]  |

**If needing urgent review/admission, please ring the hospice on 01723 356043 to discuss with the relevant team**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer:** |  | **Role:** |  |
| **Organisation:** |  | **Tel:** |  |

|  |  |  |
| --- | --- | --- |
| **Has the patient consented to referral?** | **Yes** [ ]  **No** [ ]  | ***Please note we cannot accept referrals for patients with capacity who have not consented***  |

|  |  |
| --- | --- |
|  |  |

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| --- |
| **Primary Palliative Diagnosis**:  |
| **Relevant Past Medical History:** |
| **What is the reason for referral/current needs that require input from our services?**(Please provide/attach as much detail as possible to assist triage and to help us to deliver care) |

**Section 2: Additional Referral Information – Lymphoedema Clinic ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Weight** |  |  |  |
| If BMI > 40, has the patient been referred to a dietician? | Yes [ ]  No [ ]   |  Able to transfer? | Yes [ ]  No [ ]  |
| Can they attend the clinic? | Yes [ ]  No [ ]  |  Will the patient be able to apply & remove compression hosiery? | Yes [ ]  No [ ]  |
|  Chair bound? | Yes [ ]  No [ ]  |  If not, is social help in place if required? | Yes [ ]  No [ ]  |
| **Past Medical History (tick all relevant boxes):** |  |
| DVT (within the last 6 months)Heart FailureHypertensionSVC ObstructionCellulitisLymphorrhoea (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):** |  |
| **History of swelling /onset/limb(s) affected:** |  |
| **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) |

**Section 3: 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:**  |  | **Name:** |  |
| **Relationship to person being referred:** |  | **Relationship to person being referred:** |  |
| **Diagnosis:** |  | **Date of Death (MM/YY):** |  |
| **Part 2:** |
| **Reason for Referral:** |  |
| **Are there any other counselling or mental health service providers involved?** |  |
| **Known Risks:** (to self, others or from home environment): |  |
| **Any Other Details:** |  |