**Guidance on our services available at:**

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

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

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| **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:**

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| --- | --- | --- | --- | --- |
| **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 | | |

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| **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:** |  |

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| --- | --- | --- |
| **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 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):** | | |  | | | | | | |
| **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:** | |  | | | | |