Community Specialist Palliative Care Referral Form

Phyllis Tuckwell Hospice Care	**Princess Alice Hospice Community Palliative Care Team**	**Macmillan Community Team**
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Woking & Sam Beare Hospices		**St Catherine's, Crawley**
Woking Hospice, Woking	**Sam Beare, Weybridge**	Tel: 01293 447333 Fax: 01293 447390 stcatherineshospice.admin@nhs.net
Tel: 01483 881750 Fax: 01483 881759 wokinghospice.referrals@nhs.net	Tel: 01932 826095 Fax: 01932 826094 sambearehospice.referrals@nhs.net	

Do you need advice/assessment with two working days? **Yes ☐** **No ☐**
If immediate assistance is required please phone for advice.

The specialist palliative care team offer different levels of support: telephone advice; one off assessments; admission to a hospice unit and on-going management. If you are not sure of the support you require, please telephone the palliative team for guidance.

The principles and practices of palliative care are not the exclusive concern of specialist palliative care services and the team works collaboratively with GPs, District Nurses and other health & social care professionals involved in the care of patients to ensure needs are met. The Primary Healthcare team will remain the primary point of contact for the patient and they are often able to meet the needs of many patients at the end of life.

Please send copies of any relevant recent correspondence with this form e.g. consultant clinic letters and GP patient summary. NB. Insufficient information may delay patient assessment.

FAX MESSAGE

From:

To:

Fax No:

Date:

No of pages (including cover sheet):

Additional information:

ESSENTIAL PATIENT DETAILS Referral Date:

Surname: Male ☐ Female ☐ DOB:

First Name: Known as: Age:

Address:

Town:

County:

Postcode:

Telephone:

Email:

NHS No.

Hospital No.

Ethnic status

White British	☐	Bangladeshi	☐	Other black	☐
Mixed white/ black Caribbean	☐	White Irish	☐	Other white	☐
		Mixed white/black African	☐	Pakistani	☐
Mixed white Asian	☐	Other mixed	☐	Other Asian	☐
Indian	☐	Black African	☐	Black Caribbean	☐
Chinese	☐	Other	☐	Not stated	☐

Marital status: Married ☐ Single ☐ Civil partnership ☐ Divorced ☐ Widowed ☐ Co-habiting ☐ Separated ☐

Next of Kin/Patient representatives

Surname:

First Name:

Address:

Postcode:

Telephone:

Email:

Relationship to patient:

Main Carer (if different from above)

Surname:

First Name:

Address:

Postcode:

Telephone:

Email:

Relationship to patient:

General Practitioner

Name:

Surgery:

Postcode:

Telephone:

Fax:

Secure email:

GP aware of referral: Yes ☐ No ☐ **If "No" please inform GP**

Community Nursing Services

Name:

Based at:

Telephone:

Fax:

Hub email:

Continuing Care funding in place Yes ☐ No ☐

Any communication difficulties:

Key reason for referral	**Service Requested**	**The patient is currently**
Pain/symptom management ……☐	Assessment in home……..☐	At home……☐
Emotional/psychological support…….☐	Day Hospice care……..☐	In hospital……☐
Social/financial……☐	Admission to Hospice……☐	Other care setting ……..☐
Carer support ……☐	Assessment Community Hospital……☐	(please state where)
Other reason ……..☐		

Hospital/community professional Involved with patient's care:

Name:
Based at:
Telephone:
Fax:

If in hospital, please complete the following:

Ward:
Direct Ward Ext:
Direct telephone:
Consultant:

Date of discharge:
Is hospital Palliative care team involved? Yes ☐ No ☐
If "No" please consider review by the Hospital Palliative Care Team

MRSA/C. difficile/other status: Positive ☐ Negative ☐ Not known ☐ Specify:

Diagnosis and relevant clinical history

Does the patient have capacity Yes ☐ No ☐

Has the patient consented to this referral Yes ☐ No ☐

CLINICAL INFORMATION Referral Date:

Patient Name:	**Date of Birth:**

Patient's main problems/issues (please add details explaining reason for referral)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional relevant information (psychosocial/spiritual)

Past medical & psychiatric history (please attach GP summary and details of current medication)

Patient mobility:

Drug and non-drug sensitivities/allergies Yes ☐ No ☐ Specify:

Phase of illness:	**Stable** Yes ☐ No ☐	**Unstable** Yes ☐ No ☐	**Deteriorating** Yes ☐ No	**Dying** Yes ☐ No ☐

Patient on the GSF register	Yes ☐	No ☐	Preferred place of care:
DNACPR in place (please send a copy)	Yes ☐	No ☐	Preferred place of death:
Last days of life care plan started	Yes ☐	No ☐	

Please expand on any discussions above:

Has patient been fitted with:

Implantable Cardiac Defibrillator	Yes ☐	No ☐	ICD deactivated	Yes ☐	No ☐
Has patient been told diagnosis	Yes ☐	No ☐	Is the carer aware of patient's diagnosis	Yes ☐	No ☐
Does the patient discuss the illness freely	Yes ☐	No ☐	Does the carer discuss the illness freely	Yes ☐	No ☐

Please ensure the patient is aware information will be held on computer according to the Data Protection Act and will be shared with external healthcare professionals on a need to know basis

Referrer's signature _____ Name (please print): _____

Job title: _____ Dated: _____

Contact tel: _____

Surgery or Hospital: _____ Bleep No: _____

_____ Fax no: _____