

**Hospiscare Referral Form**

***This form must be completed electronically. Please upload to your clinical system. All sections must be completed, giving as much detail as possible. On completion please send electronically to*** ***hospiscare.referrals@nhs.net******. Incomplete forms may delay response to the referral.***

|  |  |  |
| --- | --- | --- |
| **Patient has consented for Community Palliative Care Referral:** **The patient must agree to referral if they have mental capacity to do so, or a best interest decision has been made to refer**  | [ ]  **Yes** [ ]  **No** |  |

**PATIENT DETAILS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  |  | First Name |  |  | Surname |  |

|  |  |
| --- | --- |
| Gender |  |
| NHS Number |  |
| Hospital Number |  |
| Date of Birth |  |
| Age |  |
| Home Phone |  |
| Mobile Phone |  |
| Ethnicity |  |
| Marital Status |  |

|  |  |
| --- | --- |
| Address Line 1 |  |
| Address Line 2 |  |
| Address Line 3 |  |
| Address Line 4 |  |
| Post Code |  |

 Patient lives alone: YES/NO

**NEXT OF KIN / MAIN CARER**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  |  | First Name |  |  | Surname |  |

|  |  |
| --- | --- |
| Relationship to patient |  |
|  |  |
|  |  |
| Home Phone |  |
| Mobile Phone |  |

|  |  |
| --- | --- |
| Address Line 1 |  |
| Address Line 2 |  |
| Address Line 3 |  |
| Address Line 4 |  |
| Post Code |  |

**CURRENT PLACE OF CARE**:

[ ]  Own Home [ ]  Nursing Home [ ]  Community Hospital [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Acute Hospital Please state the ward

What is the estimated date of discharge? \_\_/\_\_/\_\_\_\_

**NB Please telephone 01392 688024 when the patient is discharged**

**General Practitioner**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  |  | First Name |  |  | Surname |  |

|  |  |
| --- | --- |
| Surgery |  |
| Phone |  |

|  |  |
| --- | --- |
| Address Line 1 |  |
| Address Line 2 |  |
| Address Line 3 |  |
| Address Line 4 |  |
| Post Code |  |

**CLINICAL DETAILS – Please attach GP Summary and any other relevant information**

|  |  |
| --- | --- |
| MAIN DIAGNOSIS |   Date of Diagnosis: |
|  OTHER DIAGNOSIS |  |

|  |  |
| --- | --- |
| OTHER DIAGNOSIS |  |

**PAST MEDICAL HISTORY**

|  |  |
| --- | --- |
| Please include relevant past medical history and anything we should know before we contact the patient |  |

**REASON FOR REFERRAL**

[ ] Complex, distressing or refractory symptoms relating to their advanced illness

[ ] Specialist care in the dying phase of illness, including bereavement needs of the family

[ ] Complex or profound psychological, emotional, social, spiritual or existential distress

 relating primarily to their advanced illness and requiring an holistic and expert palliative

 care approach

[ ] Advance care planning discussions and advice

[ ] Bereavement support arising from a recent death, when additional support is required

 to adjust to the loss

**URGENCY OF REFERRAL**

[ ] Within 24 hours (please telephone Clinical Admin on 01392 688024 or W/E and B/H 01392 688041)

[ ] Within 2 working days

[ ] Within 1 week

|  |  |
| --- | --- |
| Please state details if this is an urgent referral |  |

Would this patient be able to attend an outpatient clinic? [ ]

**INSIGHT**

|  |  |
| --- | --- |
| Has the patient been told of diagnosis? | [ ]  Yes [ ]  No [ ]  Not Discussed |
| Is the patient expected to die within? | [ ]  Hours [ ]  Days [ ]  Weeks [ ]  Months [ ]  Years |
| Is the carer aware of patient’s diagnosis? | [ ]  Yes [ ]  No [ ]  Not Discussed |
| Has the prognosis been discussed with the patient? | [ ]  Yes [ ]  No [ ]  Not Discussed |
| Has the prognosis been discussed with the carer | [ ]  Yes [ ]  No [ ]  Not Discussed |

**ADVANCED CARE PLANNING**

|  |  |  |
| --- | --- | --- |
| Has the patient/family expressed a preferred place of care? (PPC) | [ ]  Yes [ ]  No  |  |
| Where is this? | [ ]  Home [ ]  Hospice [ ]  Care Home [ ]  Community Hospital [ ]  RD and E. [ ]  Other |
|

|  |  |  |
| --- | --- | --- |
| Preferred place of death? (PPD) | [ ]  Yes [ ]  No  |  |
|  | [ ]  Home [ ]  Hospice [ ]  Care Home [ ]  Community Hospital [ ]  RD and E. [ ]  Other |

Does the patient have EPaCCS (special message on DDOCS system)Does the patient have a TEP form?Is the patient for an attempt at resuscitation?Does the patient have JIC meds?Does the patient’s GP give consent for a Hospiscare RN to verify if your patient has an expected death? | [ ]  Home [ ]  Hospice [ ]  Care Home [ ]  Community Hospital [ ]  RD and E. [ ]  Other[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No |

**Person completing this form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  |  | Role |  |  | Date |  |
| Telephone |   |  |  |  |  |  |  |