

**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***](mailto: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 |  |  |  |  |  |  |  |