**REFERRAL FORM – PLEASE FULLY COMPLETE BOTH SIDES**

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| **Patient Name:** | |
| **Home Address:** | |
|  | **Postcode:** |
| **Telephone Number:** | **Mobile Number:** |
| **Date of Birth:** | **Gender:** |
| **NHS Number:** | **Hospital Number:** |

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| **Current Location:** | **Lives Alone:** | Yes | 🞏 | No | 🞏 |
| **Main Carer:** | **Relationship:** | | | | |
| **Carers Address:** | | | | | |
|  | **Postcode:** | | | | |
| **Telephone Number:** | **Mobile Number:** | | | | |

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| **Referred for:** | | **Urgency of Referral:** | |
| Outpatient | 🞏 | Emergency \* (contact within 12 hours) | 🞏 |
| Wellbeing Hwb | 🞏 | Contact within 2 days | 🞏 |
| Inpatient Admission | 🞏 Contact within 7 days\*\* 🞏 | | |
| Inpatient Respite | 🞏 |  | |
| Physiotherapy | 🞏 |  | |
| Occupational Therapy 🞏  Dementia Service 🞏  (Admiral Nurse)  *\*If urgent, please telephone for immediate advice | \*\* For Outpatient/Physiotherapy* | | | |

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| **Diagnosis:** | | | | | | |
| **Reason for Referral:** | Symptom Management | 🞏 | End of Life Care | 🞏 | Psycho Social | 🞏 |
| **Information to support referral e.g. active problems:** | | | | | | |

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| **Expectations of admission / attendance (what has been discussed with patients’ family):**  *Day Therapy is up to 12 weeks planned. Inpatient Unit is not long stay – 7-10 days assessment* | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the patient given consent for the referral and for their information (personal and sensitive) being shared with St Kentigern Hospice?** | | | | | | | | | | | | | | | Yes | | 🞏 | | | No | | 🞏 | | |
| *Is the patient and family aware of:* | | | **Patient** | | | | | | | | | | | **Family / Carer** | | | | | | | | | | |
| **Diagnosis** | | | Yes | 🞏 | | | | | No | | | 🞏 | | Yes | | | | | 🞏 | | No | | | 🞏 |
| **Prognosis** | | | Yes | 🞏 | | | | | No | | | 🞏 | | Yes | | | | | 🞏 | | No | | | 🞏 |
| **Referral** | | | Yes | 🞏 | | | | | No | | | 🞏 | | Yes | | | | | 🞏 | | No | | | 🞏 |
| Has resuscitation been discussed with patient and / or family? | | | | | | | | | | | | | | Yes | | | | | 🞏 | | No | | | 🞏 |
| Patient’s resuscitation status: | | **FOR CPR** | | | 🞏 | | | | | | **NOT FOR CPR** | | | | | 🞏 | | | | | | | *(Please tick)* | |
| **Phases of illness** *(please tick):* | | | | | | | | | | | | | | | | | | | | | | | | |
| Stable: | 🞏 | | | | | | | | | | | | | | | | | | | | | | | |
| Unstable: | 🞏 | | | | | | | | | | | | | | | | | | | | | | | |
| Deteriorating: | 🞏 | | | | | | | | | | | | | | | | | | | | | | | |
| Dying: | 🞏 | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred Place of Care: | | | | | | | Preferred Place of Death: | | | | | | | | | | | | | | | | | |
| **Have any of the following been discussed?** | | | | | | | | | | | | | | | | | | | | | | | | |
| Advanced Care Planning: | | | | | | Yes | | 🞏 | | No | | | 🞏 | | | | | | | | | | | |
| Advanced Decision to Refuse Treatment: | | | | | | Yes | | 🞏 | | No | | | 🞏 | | | | | | | | | | | |
| Lasting Power of Attorney: | | | | | | Yes | | 🞏 | | No | | | 🞏 | | | | | | | | | | | |
| Ceiling of Care: | | | | | | Yes | | 🞏 | | No | | | 🞏 | | | | | | | | | | | |
| **Performance Status** *(please tick):* | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Normal activity with effort. Some signs of symptoms of disease | | | | | | | | | | | | | | | | | | 🞏 | | | | | | |
| 1. Considerable assistance and frequent medical / nursing care required | | | | | | | | | | | | | | | | | | 🞏 | | | | | | |
| 1. In bed 50% of the time | | | | | | | | | | | | | | | | | | 🞏 | | | | | | |
| 1. Total bedfast, requiring extensive nursing care by professional and / or family | | | | | | | | | | | | | | | | | | 🞏 | | | | | | |

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| **Current medications and any recent changes:** | | | | | | | | | |
| **Alerts:** | | | | | | | | | |
| Allergies | Yes | 🞏 | No | 🞏 | Infection | Yes | 🞏 | No | 🞏 |
| ICD’s | Yes | 🞏 | No | 🞏 | *Please specify* | | | | |
| Pacemaker | Yes | 🞏 | No | 🞏 |
| Oxygen Therapy  If yes how many litres: | Yes | 🞏 | No | 🞏 |

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| **GP’s Name:** | | | | | | |
| **GP’s Address:** | | | | | | |
|  | | | | | | **Postcode:** |
| **Telephone Number:** | | | | | | **Fax Number:** |
| **District Nursing:** | Yes | 🞏 | | No | 🞏 | **District Nursing Team:** |
| **Telephone Number:** | | | | | | **Fax Number:** |
| **Specialist Palliative Care CNS:** | | |  | | | |
| **Consultant(s):** | | |  | | | |
| **Others (e.g. Oncology, Dietician, Care Providers / Agencies, Hospice at Home etc.):** | | | | | | |

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| **Any other information:** | |
| **Referral by:** | *(Please print)* |
| **Telephone Number:** | **Date:** |
| **Signed:** | |