**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
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| 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 TherapyIf 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:**  |