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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **IPU** |  | **WELLBEING HWB\*** | **URGENCY** |
| Respite |  | Physio |  | Emergency\* – contact within 12 hrs |  |
| OT |  |
| Symptom Management |  | Comp Therapy |  | Contact within 2 days |  |
| Family Support |  |
| EOLC |  | Admiral |  | Contact within 7 days |  |
| Wellbeing programme |  |
| ***\*This list is not exhaustive, please phone for advice*** | Music Therapy |  | ***\*if urgent please phone for advice*** |
| Craft |  |

|  |
| --- |
| **Diagnosis:**  |
| **Information to support referral e.g. active problems:**  |

|  |
| --- |
| **Expectations of admission / attendance (what has been discussed with patients’ family):** *WBH approximately 8 sessions. 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 | 🞏Additional information: |
| 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
 | 🞏 |

|  |
| --- |
| **Current medications and any recent changes:**  |
| **Alerts:** |
| Allergies | Yes | 🞏 | No | 🞏 | Infection | Yes | 🞏 | No | 🞏 |
| ICD’s | Yes | 🞏 | No | 🞏 | MH issues | Yes | 🞏 | No | 🞏 |
| Pacemaker | Yes | 🞏 | No | 🞏 | RIG / PEG | Yes | 🞏 | No | 🞏 |
| Oxygen TherapyIf yes how many litres: | Yes | 🞏 | No |  🞏 | Falls | Yes | 🞏 | No | 🞏 |
| Other: |

|  |
| --- |
| **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.):** |

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