**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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| **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 |  |

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

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| **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 | | | | | | | | | | | | | | | | | | 🞏 | | | | | | |

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| **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 Therapy  If yes how many litres: | Yes | 🞏 | No | 🞏 | Falls | Yes | 🞏 | No | 🞏 |
| Other: | | | | |

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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:** | |