

# Community Specialist Palliative Care Referral Form

St Catherine's Hospice, Crawley

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# ST CATHERINE'S HOSPICE

**Do you need advice/assessment within two working days?**

Yes

No

**If immediate assistance is required please phone for advice.**

The specialist Palliative Care Team offer different levels of support: telephone advice; one off assessments; admission to a hospice unit and on-going management. If you are not sure of the support you require, please telephone the Palliative Team for guidance.

The principles and practices of palliative care are not the exclusive concern of specialist palliative care services and the team works collaboratively with GPs, District Nurses and other health & social care professionals involved in the care of patients to ensure needs are met. The Primary Healthcare Team will remain the primary point of contact for the patient and they are often able to meet the needs of many patients at the end of life.

**Please send copies of any relevant recent correspondence with this form e.g. Consultant clinic letters and GP patient summary.** NB. Insufficient information may delay patient assessment.

**Additional information:**

Confidentiality: The content of this form and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above.

# ESSENTIAL PATIENT DETAILS

Referral Date: \_\_\_\_\_

Surname: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB: _____
First Name: _____	Known as: _____		Age: _____
Address: _____			
Town: _____	<b>Ethnic status</b>		
County: _____	White British <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other black <input type="checkbox"/>
Postcode: _____	Mixed white/black Caribbean <input type="checkbox"/>	White Irish <input type="checkbox"/>	Other white <input type="checkbox"/>
Telephone: _____	Mixed white/Asian <input type="checkbox"/>	Mixed white/black African <input type="checkbox"/>	Pakistani <input type="checkbox"/>
Email: _____	Indian <input type="checkbox"/>	Other mixed <input type="checkbox"/>	Other Asian <input type="checkbox"/>
NHS No. _____	Chinese <input type="checkbox"/>	Black African <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>
Hospital No. _____		Other <input type="checkbox"/>	Not stated <input type="checkbox"/>

Marital status: Married  Single  Civil partnership  Divorced  Widowed  Co-habiting  Separated

Next of Kin/Patient representatives	General Practitioner
Surname: _____	Name: _____
First Name: _____	Surgery: _____
Address: _____	Postcode: _____
Postcode: _____	Telephone: _____
Telephone: _____	Fax: _____
Email: _____	Secure email: _____
Relationship to patient: _____	GP aware of referral: Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If "No" please inform GP</b>
	Community Nursing Services
	Name: _____
	Based at: _____
	Telephone: _____
	Fax: _____
	Hub email: _____

Main Carer (if different from above)	Continuing Care funding in place Yes <input type="checkbox"/> No <input type="checkbox"/>
Surname: _____	<b>Any communication difficulties:</b> _____
First Name: _____	
Address: _____	
Postcode: _____	
Telephone: _____	
Email: _____	
Relationship to patient: _____	

Key reason for referral	Service Requested	The patient is currently
Pain/symptom management ..... <input type="checkbox"/>	Assessment in home..... <input type="checkbox"/>	At home..... <input type="checkbox"/>
Emotional/psychological support..... <input type="checkbox"/>	Day Hospice care..... <input type="checkbox"/>	In hospital..... <input type="checkbox"/>
Social/financial..... <input type="checkbox"/>	Admission to Hospice..... <input type="checkbox"/>	Other care setting ..... <input type="checkbox"/>
Carer support ..... <input type="checkbox"/>	Assessment Community Hospital..... <input type="checkbox"/>	(please state where)
Other reason ..... <input type="checkbox"/>		

Hospital/community professional Involved with patient's care:	If in hospital, please complete the following:	
Name: _____	Ward: _____	Date of discharge: _____
Based at: _____	Direct Ward Ext: _____	Is Hospital Palliative Care Team involved? Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone: _____	Direct telephone: _____	If "No" please consider review by the Hospital Palliative Care Team
Fax: _____	Consultant: _____	

MRSA/C. difficile/other status: Positive  Negative  Not known  Specify: \_\_\_\_\_

**Diagnosis and relevant clinical history**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the patient have capacity Yes  No  Has the patient consented to this referral Yes  No

**CLINICAL INFORMATION**

**Referral Date:**

<b>Patient Name:</b>		<b>Date of Birth:</b>	
Patient's main problems/issues (Please add details explaining reason for referral)			
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
Additional relevant information (psychosocial/spiritual)			
Past medical & psychiatric history (please attach GP summary and details of current medication)			
Patient mobility:			
<b>Drug and non-drug sensitivities/allergies</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Specify:			
<b>Phase of illness:</b>	<b>Stable</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Unstable</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Deteriorating</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Dying</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient on the GSF register	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Preferred place of care:
DNACPR in place (please send a copy)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Preferred place of death:
Last days of life care plan started	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Please expand on any discussions above:</b>			
<b>Has patient been fitted with:</b>			
Implantable Cardiac Defibrillator	Yes <input type="checkbox"/> No <input type="checkbox"/>	ICD deactivated	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has patient been told diagnosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the carer aware of patient's diagnosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient discuss the illness freely	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the carer discuss the illness freely	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Please ensure the patient is aware information will be held on computer according to the Data Protection Act and will be shared with external healthcare professionals on a need to know basis</b>			
Referrer's signature	Name		
_____	(please print): _____		
Job title:	Dated:		
_____	_____		
Contact tel:	_____		
_____	Bleep No: _____		
Surgery or Hospital:	Fax no: _____		
_____	_____		