Community Specialist Palliative Care Referral Form

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| **St Catherine’s Hospice, Crawley****Tel:** 01293 447333**Email:**stch.admin@nhs.net  | A black and orange text  Description automatically generated |
| **Do you need advice/assessment within two working days? Yes** [ ]  **No** [ ] **If immediate assistance is required, please phone for advice.****\*Please note that all referrals will be reviewed by our clinical team and the urgency of our response will be dependent upon the information given by the referrer.****Please send copies of any relevant recent correspondence with this form** |
| 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 St Catherine’s Hospice Advice Line on 01293 447333.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. |
| 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. |
|  **Referral Date**:  |
| **ESSENTIAL PATIENT DETAILS:****Surname**:  **First Name**:**Known as**:**Date of Birth**:**Age**: **Male**: [ ]  **Female**: [ ] **NHS number**:**Address**: **Telephone number**: **E-mail address**:  | **Ethnic Status:**White British [ ]  Bangladeshi [ ]  Other black [ ] Mixed white/ [ ]  White Irish [ ]  Other white [ ] black CaribbeanMixed white/black African [ ]  Pakistani [ ] Mixed white Asian [ ]  Other mixed [ ]  Other Asian [ ] Indian [ ]  Black African [ ]  Black Caribbean [ ] Chinese [ ]  Other [ ]  Not stated [ ]  |
| **Marital status:** | Married [ ]   | Single [ ]   |  | Civil partnership [ ]  | Divorced [ ]  | Widowed [ ]  | Co-habiting [ ]  | Separated [ ]  |

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| **Next of Kin/Patient representatives** | **General Practitioner** |
| **Surname**:**First Name**:**Address**:**Telephone number**:**E-mail address**: **Relationship to patient**: **NOK aware of referral:** Yes [ ]  No [ ]   | **GP Name**:**Surgery Name**:**Surgery Address**:**Telephone**:**Secure e-mail address**: **GP aware of referral**: Yes [ ]  No [ ]  **If “no” please inform GP** |
| **Key reason for referral:** | **Service Required:** | **The patient is currently:** |
| Pain/symptom management.……..[ ] Emotional/psychological support...[ ] Social/financial………………….[ ] Carer support………………………[ ] Other reason……………………….[ ]  | Community Palliative Care……………..[ ] Carers Support…………………………..[ ] Emotional/Counselling Support………..[ ] Hospice at Home………………………..[ ] Inpatient Care……………………………[ ] Social Work………………………………[ ] Welfare Advice…………………………..[ ] Living Well Centre……………………….[ ] Therapies…………………………………[ ]  | At home………………………………[ ] In hospital……………………………[ ]  Other care setting…………………….[ ] (please state where) |
| **CLINICAL INFORMATION** |
| **Diagnosis, including disease trajectory and status**:  |
| **Does the patient have capacity**: Yes [ ]  No [ ]  | **Has the patient consented to this referral**:Yes [ ]  No [ ]  |
| **Patient’s key problems/issues that require palliative care input**:  |
| **Does the patient have a ReSPECT form or an Advanced Care Plan in place?**: |
| **Psychosocial information**:  |
| **Safeguarding and lone worker risks:** |
| **Patient mobility**: |
| **Communication/Cognition issues**: |
| **Drug and non-drug sensitivities/allergies**: |
| **Phase of illness:** | Stable [ ]  | Unstable [ ]  | Deteriorating [ ]  | Dying [ ]   |
|  **Has patient been told diagnosis?** Yes: [ ]  No: [ ]  **Does the patient discuss the illness freely?** Yes: [ ]  No: [ ]   |
| **Additional information:** |
|  **Referrer’s Details:** |
|  **Referrer’s Name**: **Referrer’s Job Title**: **Referring Organisation Name**:  **Contact Telephone Number**: **Contact e-mail address**:  **Date**: **Referrer’s Signature**:………………….  |
| 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.  |