Specialist Palliative Care Referral Form

Send this form by NHS secure email

Date referral received:
Time received:

Phyllis Tuckwell Hospice Care ☐ Tel: 01252 729440 PTH.adviceandreferral@nhs.net	**Princess Alice Hospice at Home Team** ☐ Tel: 01372 461804 SDCCG.clinicaladminpah@nhs.net	**Macmillan Community Team** ☐ Tel: 01730 811121 SC-TR.MidhurstMacmillan@nhs.net
Woking & Sam Beare Hospices, Woking ☐ Tel: 01483 881750 wsbh.referrals@nhs.net		**St Catherine's Hospice, Crawley** ☐ Tel: 01293 447333 stcatherineshospice.admin@nhs.net

Is the referral urgent due to rapidly changing needs? If 'Yes' phone the appropriate team for advice /assessment	**Yes** ☐	**No** ☐

The patient consented to this referral/best interest decision has been made? Yes ☐

If patient lacks capacity to consent, has their relevant other been informed? Yes ☐ **No** ☐ (confirm details)

Please send copies of any relevant recent correspondence to assist responsive assessment e.g. consultant clinic letters, discharge summary and GP patient summary plus CPR status if known.

ESSENTIAL DETAILS FOR PERSON BEING REFERRED

Surname	Surname	Date of birth	Date of Birth
First name	Given Name	NHS number	NHS Number
Marital Status	Married ☐ Single ☐ Civil partnership ☐	Cohabiting ☐	Widowed ☐ Divorced ☐ Separated ☐
Known as	Calling Name		Male ☐ Female ☐
Address and post code	Home Full Address (stacked)	Does the person live alone?	**Key Safe No.**
		Email	**Patient E-mail Address**
Telephone number	Patient Home Telephone	Mobile number	Patient Mobile Telephone

Next of Kin/Patient representative		**tick if LPA** ☐	**Main Carer (if different)**		
Surname		Address if different to patient	Surname		Address if different to patient
First Name			First Name		
Telephone			Telephone		
Email			Email		
Relationship to patient			Relationship to patient		

Patient's ethnic origin and religion

White	White – British ☐	White – Irish ☐	Black or Black British	African ☐	Caribbean ☐	Asian or Asian British	Indian ☐ Pakistani ☐
	White – other ☐			White and Black Caribbean ☐			Bangladeshi ☐
	Any other mixed ☐			White and Black African ☐			White and Asian ☐
Other	Chinese ☐ Other ☐	Not stated ☐		Other Black/ African/ Caribbean ☐			Any other Asian background ☐
Religion				First language			

General Practitioner		**Community Nursing Services**	
Name	Usual GP Full Name	DN team	
Surgery	Organisation Name	DN base tel. no.	
Telephone	Organisation Telephone Number	DN mobile no.	
Secure nhs.net email	Organisation E-mail Address	Secure nhs.net email	
GP aware of referral:	Yes ☐ No ☐ **If "No" please inform GP**	Out of hours DN numbers	

Community professional involved with patient's care		**If in hospital, please complete the following:**			
		Name of hospital		Hospital number	**Hospital Number**
Name	Patient Carers	Ward		**Date of discharge:**	
Role		Direct ward		Place of discharge:	

Based at		telephone		Is the patient being discharged home to die? Yes ☐ No ☐
Telephone		Consultant		Is Hospital Palliative Care Team involved? Yes☐ No ☐

CLINICAL REFERRAL INFORMATION (please attach GP summary and details of current medication

Is the patient living with an advanced or terminal illness? Yes ☐ No ☐

Initial contact		
	The patient is able to attend an outpatient setting	☐
	The patient can only be seen at home (requires considerable assistance, or in bed >50% of the time). For Care at Home assessment.	☐
	The patient requires inpatient admission for symptom management or terminal care	☐

Patient's main problems/needs (please add details explaining reason for referral).
Highlight any oxygen needs, moving and handling or skin integrity concerns.

1.
2.
3.
4.
5.
6.

Diagnosis and relevant clinical history | Past medical & psychiatric history | Additional relevant information (psychosocial/spiritual)

Has patient been told diagnosis?	Yes ☐	No ☐	Is the carer aware of patient's diagnosis?	Yes ☐	No ☐
Does the patient discuss the illness freely?	Yes ☐	No ☐	Does the carer discuss the illness freely?	Yes ☐	No ☐

Phase of illness				**Does patient have any of the following?**	Yes	No	**The patient is currently**	
Stable	☐	Unstable	☐	PACE document	☐	☐	At home	☐
				Advance Care Plan	☐	☐	In hospital (specify below)	☐
Deteriorating	☐	Dying	☐	Other care/ management plan eg. ReSPECT, DNACPR	☐	☐	Other care setting (state where)	☐
Preferred place of care:				Resuscitation status (specify)				

Communication Does the patient have problems with:	Hearing ☐	Sight ☐	Speech ☐
Does the patient have cognitive impairment? Yes ☐ No ☐	Patient conscious ☐	Semi-conscious ☐	Unconscious ☐

Known concerns or risks	Yes	No	Tick box and add details
Are there any known **allergies?**	☐	☐	
Are there any lone worker concerns?	☐	☐	

Any current or previous safeguarding concerns?

Relevant family member/ main carer information including any potential risks

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

Referred by (print name) ______________________ Date of referral ______________

Work base ______________________ Contact telephone ______________

Job title