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PALLIATIVE CARE REFERRAL FORM

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| **Referrals can be made electronically via SystmOne, by phone or email**  **All urgent referrals should be made by phone** | |
| 1. **Palliative Care Team**   Hospital  Community  **Tel: 01423 553464**  **Electronic referrals accepted via SystmOne or email:** [**hdft.palliativecareteam@nhs.net**](mailto:hdft.palliativecareteam@nhs.net) | 1. **Saint Michael’s Hospice**   Inpatient unit (GPs and PCT only)  Day Therapy Unit  Palliative Lymphoedema Clinic  Neurological Conditions CNS  Volunteer Visitor Service  Physiotherapy (internal referrals only)  Occupational Therapy (internal referrals only)  Social Work (internal referrals only)  Spiritual/pastoral service (internal referrals only)  **Electronic referrals accepted via SystmOne**  **Routine referrals Tel: 01423 879687**  **Urgent referrals only Tel: 01423 872658** |

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| Patient Name:  Prefers to be called: | NHS no: |
| Hospital no: |
| Address: | Date of birth: |
| Telephone: |
| Mobile no: |
| Key code: | Lives alone: Yes / No |
| Does the patient have communication issues? Yes/No  If yes, what are they? | |
| Current location of Patient:  Home  HDFT Ward \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date of admission \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  Other Hospital Location \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  Care Home Name \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | |
| NOK/contact name:  Relationship:  Telephone number:  Is this person Next of Kin? Yes/No  Main Carer? Yes/No | GP:  Surgery:  Tel: |
| Nursing/other care teams involved: |
| Has patient consented to referral? Yes/No  Is relative aware of referral? Yes/No |

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| Diagnosis, treatment & relevant medical history: | |
| **MAIN CONCERNS - REASON FOR REFERRAL** (referrals can be for physical, psychological, social and spiritual problems):  Continue on separate sheets | |
| Is a DNACPR in place? Yes / No | |
| **Saint Michael’s Hospice referrals ONLY:**  Detail any supportive interventions e.g. PEG feeding, NIV, oxygen (NB if on oxygen specify L/min)  If patient smokes are they aware that they cannot smoke within the hospice building? YES / NO / N/A  Level of mobility (e.g. aids used):  Access to patient’s home (e.g. steps, flat, multi-level etc): | |
| Name of referrer: | Date of referral: |
| Position: | Contact no: |

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| Date / time referral received: | By: | Signature: |

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