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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**

HospitalCommunity**Tel: 01423 553464** **Electronic referrals accepted via SystmOne or email:** **hdft.palliativecareteam@nhs.net** | 1. **Saint Michael’s Hospice**

Inpatient unit (GPs and PCT only)Day Therapy UnitPalliative Lymphoedema Clinic Neurological Conditions CNSVolunteer Visitor ServicePhysiotherapy (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/NoMain Carer? Yes/No | GP:Surgery:Tel: |
| Nursing/other care teams involved: |
| Has patient consented to referral? Yes/NoIs 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/ALevel 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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