

Community Specialist Palliative Care Referral Form

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Woking & Sam Beare Hospices <table border="0"> <tr> <td data-bbox="105 439 587 584"> Woking Hospice, Woking Tel: 01483 881750 Fax: 01483 881759 wokinghospice.referrals@nhs.net </td> <td data-bbox="587 439 1070 584"> Sam Beare, Weybridge Tel: 01932 826095 Fax: 01932 826094 sambearehospice.referrals@nhs.net </td> </tr> </table>		Woking Hospice, Woking Tel: 01483 881750 Fax: 01483 881759 wokinghospice.referrals@nhs.net	Sam Beare, Weybridge Tel: 01932 826095 Fax: 01932 826094 sambearehospice.referrals@nhs.net	St Catherine's, Crawley Tel: 01293 447333 Fax: 01293 447390 stcatherineshospice.admin@nhs.net
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Do you need advice/assessment with two working days? Yes <input type="checkbox"/> No <input type="checkbox"/> If immediate assistance is required please phone for advice.				
<p>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.</p> <p>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.</p>				
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.				
<h2>FAX MESSAGE</h2>				
From:				
To:				
Fax No:				
Date:				
No of pages (including cover sheet):				
Additional information:				
<p>Confidentiality: the content of this fax 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.</p>				

ESSENTIAL PATIENT DETAILS

Referral Date: _____

Surname: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB: _____
First Name: _____	Known as: _____		Age: _____
Address: _____			
Town: _____	Ethnic status		
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"/> If "No" please inform GP

Main Carer (if different from above)	Community Nursing Services
Surname: _____	Name: _____
First Name: _____	Based at: _____
Address: _____	Telephone: _____
Postcode: _____	Fax: _____
Telephone: _____	Hub email: _____
Email: _____	
Relationship to patient: _____	

Continuing Care funding in place Yes No

Postcode: _____ Telephone: _____ Email: _____ Relationship to patient: _____	Any communication difficulties:
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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
Fax: _____	Consultant: _____	Hospital Palliative Care Team

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: _____

Patient Name: _____	Date of Birth: _____
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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: _____

Drug and non-drug sensitivities/allergies Yes No Specify: _____

Phase of illness:	Stable Yes <input type="checkbox"/> No <input type="checkbox"/>	Unstable Yes <input type="checkbox"/> No <input type="checkbox"/>	Deteriorating Yes <input type="checkbox"/> No <input type="checkbox"/>	Dying Yes <input type="checkbox"/> No <input type="checkbox"/>
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Patient on the GSF register	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"/>	Preferred place of death:
Last days of life care plan started	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Please expand on any discussions above:

Has patient been fitted with:

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"/>

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

Referrer's signature _____ Job title: _____ Contact tel: _____ Surgery or Hospital: _____	Name _____ (please print): _____ Dated: _____ Bleep No: _____ Fax no: _____
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