Health and Social Care

CONFIDENTIAL

ALL FIELDS MUST BE COMPLETED. PLEASE NOTE THAT IF THE REFERRAL FORM IS INCOMPLETE IT MAY LEAD TO A DELAY IN PROCESSING SAME

Hospice Use Only	Date received:	Ref No:

REFERRAL TO COMMUNITY AND INPATIENT UNIT SPECIALIST PALLIATIVE CARE SERVICES

Patient Name		Date of Birth	
H&C No		Sex	
Address		Marital Status	
		Ethnic Origin	
Post Code		Religion	
Tel No		Occupation	
Mobile No		No of Dependents (under 18 years)	
Next of Kin		**Main Carer (if different from Next of Kin)**	
Name		Name	
Address		Address	
Post Code		Post Code	
Tel No		Tel No	
Mobile No		Mobile No	
Relationship to Patient		Relationship to Patient	
Referrer		**GP**	
Name of Referrer		Name of GP	
Address		Address	
Post Code		Post Code	
Tel No		Tel No	
District Nurse		**Other Healthcare Professional**	
Name of DN		Consultant	
Address		Palliative Care Nurse Specialist	
		Palliative Medicine Consultant	
Post Code		Social Worker	
Tel No		Other	

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ELCOS Status							
A = may be years	☐	B = Could be last year	☐	C = Possibly months/weeks	☐	D = Probably last few days	☐

Reason for Referral (please select)		Service(s) Requested (please select)	
Symptom Management	☐	Inpatient Unit Admission	☐
Rehabilitation	☐	Day Therapy	☐
End of Life Support	☐	Outpatient Clinic	☐
		Community Palliative Care Nurse Specialist	☐
Other (please specify)		Other (please specify)	

The patient is currently (please select one option)			
At Home	☐	At Hospital	☐
At Nursing Home	☐	Other (please specify)	☐

Patient Diagnosis	
Primary Diagnosis and date	
Secondary Diagnosis and date	
Histology (if known)	
Current problems	(enter details of unresolved complex physical, social, psychological and spiritual symptoms including concerns affecting carer/family, give details of what interventions you have trialled)
Treatments to date and further treatment planned	(enter details of Consultant and hospital for all treatments)

Additional Information (e.g. details of results from previous scans, x-rays, blood tests, etc)

Past Medical History

IF THIS REFERRAL REQUIRES AN URGENT RESPONSE IT MUST BE ACCOMPANIED BY TELEPHONE CONTACT FROM THE REFERRER

Medication						
Current medication as per discharge letter (obligatory)	☐	Syringe Pump				
Known Allergies (enter details)						
Mobility (please select all that are appropriate)	Mobile	☐	Mobile with difficulty (stiffness, pain)	☐		
	Mobile with assistance, equipment or aids	☐	Immobile	☐		
Oxygen Therapy (enter details)						
Nutritional Therapy (please select all that are appropriate)	Oral	☐	PEG	☐	NG	☐
	Any feeding difficulties?					
Infection Status e.g. MRSA, C.Diff, Pseudomonas (enter details)						

Advance Care Plan						
Has an Advance Care Plan been completed? (if yes, please forward details)	Yes	☐	No	☐	N/A	☐

Preferred Place of Care	
Please state Patient's preferred place of care	
Date	

CPR Status						
Has CPR Status been discussed with the patient?	Yes	☐	No	☐		
Current Status (please select)	DNACPR	☐	For CPR	☐	Not Known	☐
Has GP been notified of status?	Yes	☐	No	☐		

Care Package						
Is there a care package in place?	Yes	☐	No	☐	N/A	☐
If you have answered Yes to the above question, please enter details						

Communication	
Is the patient experiencing communication difficulties? Please enter details including if an interpreter is required.	

Patient Insight					Next of Kin/Main Carer Insight				
Has the patient agreed to this referral?	Yes	☐	No	☐	Is the NOK/Main Carer aware of the referral?	Yes	☐	No	☐
Is the patient aware of their diagnosis?	Yes	☐	No	☐	Is the NOK/Main Carer aware of the patient's diagnosis?	Yes	☐	No	☐
If No, please explain why the patient is not aware of their diagnosis.					If No, please explain why NOK/Main Carer is not aware of the diagnosis.				
Has prognosis been discussed with the patient?	Yes	☐	No	☐	Has prognosis been discussed with NOK/Main Carer?	Yes	☐	No	☐
If No, please explain why the prognosis has not been discussed.					If No, please explain why the prognosis has not been discussed.				

Submission				
Has the Patient's GP been made aware of this referral by the Referrer (Community only)?	Yes	☒	No	☐
Please confirm name of GP contacted and date of call			Date	
Authorisation				
Please confirm that you have reviewed this form and all relevant information has been completed (please insert your name as your signature)			Date	
Designation of Referrer				

PLEASE COMPLETE ADDITIONAL INFORMATION FOR MARIE CURIE NURSING SERVICES

Marie Curie

Please complete the following additional information for Marie Curie Nursing Service Referrals only

Additional Patient information	(Delete as necessary)
Is the patient stable, changing or urgent? (Refer to table at the end to make assessment)	**Stable Changing Urgent**
Cancer or Non-Cancer diagnosis?	**Cancer Non-Cancer**
What name does the patient like to be known as?	
Who does the patient live with?	**Name:** **Relationship:**
Patient's emergency contact name and number	**Name:** **Contact Number:**
Can we discuss the patient's care record with the next of kin/carer?	**Yes No Unknown**
Is there a care plan in the patient's home?	**Yes No Unknown**
Is the patient able to consent to care and treatment?	**Yes No Unknown**
Does the patient have any cognitive impairments? If yes, please detail	**Yes No Unknown**
Does the patient have a visual impairment? If yes please detail	**Yes No Unknown**
Any diet or fluid requirements? If yes, provide details	**Yes No Unknown**
Describe the patient's level of consciousness	
Is there a prescription for palliative care anticipatory medicine?	**Yes No Unknown**
Has a patient handling risk assessment been carried out?	**Yes No Unknown**
Any history of falls?	**Yes No Unknown**
Is the patient continent? If no, what continence management aids are in place? e.g. catheter, continence pads, commode, bed pans/other	**Yes No Unknown**
Has a recent skin assessment been undertaken? Please provide details, e.g. skin intact, grade 2 pressure ulcer on sacrum etc	**Yes No**
Hospital bed or mattress in place?	**Yes No**
Patient's preferred place of death?	**Home Care Home Hospital Hospice Unknown**
Care Package Requested	
What package of care are you requesting and hours e.g. Days & Nights, Days only, Nights only	
Are two staff required to attend the patient?	**Yes No**
Patient's Property	
Access instructions e.g. key safe code	
Any pets present in the home? If yes, provide details	**Yes No Unknown**
Does smoking take place in the home? If yes, provide details	**Yes No Unknown**
Have any hazards been identified outside of the property? If yes, provide details e.g. lighting/parking/walk/stairs.	**Yes No Unknown**
Any physical hazards with the home that could affect safe care delivery? If yes, please detail e.g. cramped space/poor light.	**Yes No Unknown**
Are supplies required by care and handling plan available in the house? e.g. slide sheet, PPE, Hoists etc.	**Yes No Unknown**
Additional information	
Out of hours number for District Nursing	
GP's locality (geographical area within HSC Trust)	

Marie Curie

Category	Inclusion Criteria
URGENT (High)	• Prognosis of hours to days • Same day/next day response is needed • Rapidly deteriorating condition • Uncontrolled symptoms, requiring nursing intervention • Carer unable to cope with changing/unpredictable demands in patient's care • Breakdown in care which will lead to an in-patient admission • Rapid discharge from in-patient setting
Patients and Families with Changing Needs (Normal)	• Prognosis of days to weeks • The patient requires a high level of nursing care • The patient's needs are changing • The patient has symptoms that are unstable • High levels of patient/carer anxiety • The needs of the family/carer are unstable with a risk of increasing further • The patient not in their preferred place of care
Patients and families with stable needs (Low)	• Prognosis of weeks to months • The patient requires a low level of nursing care • The patient is asymptomatic, or their symptoms are well controlled • The patient is deteriorating slowly • Low levels of patient/family anxiety • Planned care packages to facilitate discharge