WALES SPECIALIST PALLIATIVE CARE TEAM
REFERRAL FORM

Referral to: ....Marie Curie Hopsice ...

What is the urgency of the referral? **Urgent (within 48hours)** **Routine**

Urgent referrals include for example severe uncontrolled physical symptoms or ICP for last days of life in place
Routine referrals can be seen within a timeframe guided by the local policy of the team receiving the referral.

REGISTRATION DETAILS [Items marked with * are **mandatory** to enable correct and prompt registration]

*Surname	*Unit No./ NHS No.	*Referring medical lead (i.e. GP/ Consultant) Is Medical Lead aware? (NB. Referrals can be made by any clinical member of MDT but medical lead **must** be in agreement)	*GP name: *Practice: Tel:
*Forename	*DoB		
*Address Post Code: *Tel:		Consultants involved	
		Carer Name and Relationship: Contact Tel Number:	
Male Female			

Current Location: Home Hospital **Ward:**
Other

***DIAGNOSIS** **Cancer:** Primary site: Secondary site(s): **Non Cancer** :	*** What has the patient been told about the diagnosis & prognosis?**
IMPORTANT Is there a risk for the lone visiting clinician? Yes No If answer is yes, please expand in the Main Problems section below	*** Is the patient aware of the referral?** Yes No If answer is no, please expand below

Main Problems (please include relevant physical, social and / or psychological issues, current medication and purpose of referral.)

Regarding Covid-19: Has the patient tested positive for Covid-19 Yes No If Yes:when?

Does the patient have any symptoms of Covid-19? Yes No If yes - what are their symptoms?

Has the patient been exposed to anybody with suspected or confirmed Covid-19 in the past 14 days? Yes No

SPECIAL CONSIDERATIONS FOR COMMUNICATION REQUIRED? (eg eye-sight, hearing, cognition, language)	**SPEC PALL CARE SERVICE REQUIRED:** **COMMUNITY TEAM** **HOSPITAL TEAM**	**DAY SERVICE** **MEDICAL OPD** **CONSIDER FOR ADMISSION**
ANYTHING ELSE WE NEED TO KNOW?	INDICATE WHICH HEALTH PROFESSIONAL(S) MEDICINE ☐ NURSING OTHER PHYSIO OCC THER	

*REFERRER'S NAME:	SIGNATURE:	ROLE:	CONTACT TEL:	DATE:

ADMIN ONLY DATE RECEIVED	DATE REGISTERED:	PROFESSIONAL:

Name:

Date of birth:

Additional Information to accompany requests for hospice in-patients

admissions Has a decision regarding CPR been made?

Yes, for resuscitation
Yes, not for resuscitation and form in place
No (please comment on whether it has been discussed and is appropriate)

Has the patient/family been made aware of the limitations of hospice environment?

Yes
No (please comment further)

	No	Yes	Comment
Current, or past, history of multi-resistant organism?			
Current, or past, history of C diff infection?			
Vomiting or diarrhoea/vomiting or Norovirus in past 48 hours?			
Require oxygen?			
High risk of falls?			
Are they confused?			

Do they have any specific medication requirements (incl syringe driver)?

Do they have any equipment requirements (including bariatric equipment)?

How will the patient be transported to the hospice?

Routine ambulance transfer
End of life ambulance transfer
Own transport
Not yet known