**Specialist Palliative Care Referral Form** **- BLMK
Please tick service required**

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| [ ]  **Willen Hospice Palliative Care Service**Tel: 01908 663 636willen.hospice@nhs.net | [ ]  **Sue Ryder St John’s Hospice**Tel: 01767 642410 St John’s 01767 641349 PCHUB stjohns.referrals@nhs.net | [ ]  **Luton Community Service (CCS)**Tel: 0333 405 3000ccs-tr.lutonrmsreferrals@nhs.net |
| [ ]  **Keech Hospice** Tel: 0808 180 7788keech.mcct@nhs.net | [ ]  **Bedfordshire Community Service (ELFT)**Tel: 0345 6024064singlepoint.ofcontact@nhs.net |

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| **Any urgent referrals and requests for admission should be accompanied by a phone call**We may contact you for further clarification or to discuss the most appropriate plan of action for the patient. |

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| **The patient’s current location: (eg Hospital/Home)**  |
|  **Hospital Name: Hospital Ward: Date of Discharge:** |
| **REFERRER’S NAME JOB TITLE CONTACT NUMBER:** **Referrer’s signature: Date:** |

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| **Surname:**  | **Male** [ ]  **Female** [ ]  **Other** [ ]  |
| **First name:**  | **Known as:**  |
| **Address:** **Postcode:** **Email:** | **DIAGNOSIS:****DATE of DIAGNOSIS:** |
| **Home Tel.:****Mobile Tel.:**  | **NHS number:****DOB:** |

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| **MAIN CARER:****Relationship to patient:**  **Tel:** **Who does the patient live with?** | **NEXT of KIN** (if different): **Relationship to patient:** **Tel:**  |
| **Main Language: Interpreter needed? Yes/No****Religion: Ethnic origin: Occupation:** |
| **GP NAME:****Is GP aware of referral? Yes/No** | **Tel:** **Email:** | **Surgery Name:** |
| **DISTRICT NURSE involved Yes/No** | **Known to:**  | **Based at:** |
| **Name of other Specialist Service involved:**  | **Name of staff member:** | **Tel:** **Email** |
| **Funding for care approved: Yes /No** If in progress please forward application paperwork **Approval for: Fast Track CHC (Nursing Home)** [ ]  **(Home)** [ ]  **Social care** [ ]  |

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| **Does the patient have capacity to make decisions: Yes/No** **If No, please complete Mental capacity assessment and Best interest documentation****Has the patient consented to referral to Specialist Palliative Care: Yes/No** **Does the patient have LPA: Health Yes/No Finance: Yes/No** **Has the patient consented to share information? Yes/No Has SystmOne been shared? Yes/No**  |

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| **Have any advance care planning discussions taken place, including discontinuation of treatments and escalation plans? YES/NO****If yes, what outcomes: PPC: PPD:****Is DNACPR IN PLACE? YES/NO Is patient on EPaCCS? YES/NO** |

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| **BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS**  |
| History, tests and treatment |
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| **ALLERGY/SENSITIVITY:** |
| **MRSA Status ………... C. Diff Status …………. Covid 19………… Other infection……………**  |
| **WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?****What has the patient been told about this referral?** |
| **VULNERABILITIES/RISKS TO BE AWARE OF IN THE COMMUNITY: (eg safeguarding concerns, living conditions, family dynamics, access)** |
| **Does the patient have pressure ulcers? YES/NO If YES Category …………… Reported: YES/NO****Falls Risk? YES / NO****Mobility: Equipment:** **Approximate Weight: below 50kg** [ ]  **50-80kg** [ ]  **90-110kg** [ ]  **120-140kg** [ ]  **150kg or above** [ ] **Approximate Height: 145-155cm** [ ]  **165-175cm** [ ]  **185-195cm** [ ]  |
| **Oxygen (Including anticipated rate required)** [ ]  **…………..****Suction** [ ]  **CVAD** [ ]  **NIPPV** [ ]  **Syringe Driver** [ ]  **Feeding pump** [ ]  **Tracheostomy/ Laryngectomy** [ ]  |
| **OACC - Patients current Karnofsky Performance Status: ……………% OR** **Performance score:0-5 ……………****Phase of Illness –** *please* 🗸[ ] Stable [ ]  Unstable [ ]  Deteriorating [ ]  Dying |

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| **Main Reasons for Referral -** *please* ✓Care in the last days of life [ ]  Social/financial support (family/carer) [ ] Symptom control [ ]  Social/financial support (patient) [ ]  Emotional/psychological/spiritual support (patient) [ ]  Other (please specify) [ ] Emotional/psychological/spiritual support (family/carer) [ ]   |
| **Service requested -** *please* ✓ Subject to assessment |
| **Willen Hospice**Willen at Home Team [ ] Inpatient Care [ ] Therapeutic and Wellbeing Service [ ]  | **St John’s Hospice**Inpatient Unit [ ] Medical Outpatient [ ] Day Therapy including Lymphoedema Clinic [ ] (Own transport required for Day Therapy and Outpatient Service) | **Keech Hospice Care**Inpatient Care [ ] **Wellbeing Centre** (Luton)Nurse led clinic [ ] (including blood transfusions)Rehab [ ] (Physio, OT and Hydrotherapy)Social Work and Supportive Care Team [ ] (creative and talking therapy work, bereavement support, carer support, hospice at home volunteers and complementary therapy)**Living Well Centre** (Bedford) [ ] **Inclusive Health**  [ ]  |
| **Community Specialist Palliative Care Team** **CCS** (Luton) **Macmillan SPC CNS Team** [ ]  **CCS** (Luton) **benefits team** [ ]  **ELFT** (Bedfordshire) [ ]  |
| **24hr Advice and Support Line** (Verbal consent gained)**Palliative Care Hub** [ ]  **My Care Coordination Team** [ ]  |

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Registered charity number 270194

Registered charity number 1052076

Registered charity number 1035089

