**Palliative Care Referral Form**

Tel: 01242 230199

*Please complete this form with as much information as possible as insufficient information may delay patient assessment or admission.*

*Daily Admissions meeting for the Inpatient unit (IPU) is held at 0930 Monday- Friday.*

*Referrals to Day Hospice and Living Well Clinic are reviewed every Friday morning.*

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| **Patient details** |
| Surname: First Names:  | Civil Status: **M S W D** **P** |
| Gender: DOB: | Occupation: |
| Address:  | Ethnicity: Religion : |
| Smoker: Yes □ No □Does the patient vape? Yes □ No □ |
| Postcode: | **NHS number:**  |
| Tel: Mobile Tel: |

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

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| **Please indicate the service required below:**Admission to In-Patient Unit □ Day Hospice □ Living Well Clinic □ Out-Patient Clinic: Medical □ Physio/OT □   **Reason for referral:**Pain/symptom control □ Psychological/Spiritual Support □ End of Life Care □ *Please provide further details:* |
| **Diagnosis:** | Date of Diagnosis: |
| Sites of Metastases (If Malignancy): | Relevant PMH: |
| Patient and family’s understanding of referral to Sue Ryder: |

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| **Next of Kin:** | **District Nurse:** |
| **Relationship to patient:** | **GP and Surgery:** |
| **Address:****Telephone Number:** |
| **Specialist Palliative Care Nurse:** |
| **Consultant:** |



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| **Location of patient** | **Mobility** | **Behavioural concerns** |
| Home □ In hospital □ Care home □ Please indicate Ward/ Hospital if applicable: | Independent □Walks with aids □ please specify……………Bedbound □Chairbound □ History of falls: Yes □ No □ **Equipment needs:**Air mattress □ Syringe Driver □ PEG □ NG □ Catheter □ Suction □Oxygen □ …..L/min *we are unable to support humidified oxygen at the hospice* Other (please specify)…………………………Weight…………..Height …………..**Does the patient require bariatric equipment?**Yes □ No □Please specify…………………… | Aggression □Agitation □Poor memory□Wandering □No concerns □Other □ Please specify: |
| **Known Drug allergies:**Yes □ No □ Details: |
| **Does the patient have any communication needs?**Yes □No □Please give details: |
| DNAR in place: Yes □ No □Advance care plan in place:  Yes □ No □ |
| **Any infection risks:**Yes □ No □ Not Known □If yes please indicate issue:Date of last MRSA Screen: |

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| **Current Medication** |
| 1. | 2. | 3. | 4. |
| 5. | 6. | 7. | 8. |
| **In the box below please provide details of current medical and nursing issues; including services and healthcare professionals involved in the patient’s care.** |
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| **Name of referrer:****Job Title: Telephone number:****Email address:****Date:** | **On completion please return this form via email****Email: Leckhampton.medical@nhs.net** |