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ADULT PALLIATIVE CARE REFERRAL FORM

Birmingham Hospice is the new name for Birmingham St Mary's Hospice and John Taylor Hospice.

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| **All referrals MUST be accompanied by recent clinically relevant correspondence** |

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| **Criteria for Referral**  **The patient has a diagnosis of advanced life limiting illness and:**   * Symptom control or other complex problems, which are escalating or are unable to be managed by the current clinical team. These symptoms may be physical, psychological, spiritual, social, or family/carer orientated issues. * Has capacity & has consented to referral OR lacks capacity for this decision but it is agreed to be in their best interests. |

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| **Patient details** | | | | | | | |
| NHS Number: | Patient consents to referral for Palliative Care involvement: Yes  No  Unable | | | | | *If ‘No’ please give details on next page.* | Office use |
| Surname: | | Gender: | | | D.O.B: | |
| First Name: | | Preferred Name (if different): | | | | |
| Address: | | Ethnicity: | | | | |
|  | | Religion: | | | | |
| Postcode: | |  | | | | |
| Telephone details (1)  Landline: | | Telephone details (2)  Mobile: | | | | |
|  | | |  | | | | |
| **Referrer details** | | | | | | | |
| Referrer’s Name (please print): | | | | Signature: | | | |
| Job title: | | | | Contact number: | | | |
| Surgery /Hospital Team/ District Nurse Team: | | | | Date: | | | |

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| **Carer contact details** | | |
| Name: | Relationship to patient: | Telephone:  1)  2) |
| Name: | Relationship to patient: | Telephone:  1)  2) |

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| **GP Name:** | CCG: | Email: |
| **Practice:** | Tel No: | Fax: |

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| **District Nurse involvement:**  Yes ☐ No ☐ | Name: | Team/base:  Tel No: |
| Significant additional information (lives alone, package of care in place, Key Safe details): | | |

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| **Inpatient hospital details (if appropriate):** | | | | |
| Hospital: | | Ward: | | Hospital  Number : |
| Telephone: | Direct Ward Ext: | | Date of discharge (if known): | |
| Consultant (1): | | | Consultant (2): | |
| Hospital Palliative Care team involved: Yes  No | | | Main Hospital Team/Contact: | |

Patient Name: NHS Number:

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| **Main Diagnosis(es):** |
| **Other Significant Medical & Mental Health Problems:** |

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| **Brief history of diagnosis(es) and key treatments:** | | |
| Date | Progression of disease and investigations / treatment | Consultant and hospital |
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| **Estimated prognosis**: Days  Weeks  Months | | |
| **Urgency of referral:**  **Within 2 working days** - **MUST** be accompanied by a telephone call from referrer for immediate advice and to support level of urgency  **Within 5 working days**  **Within 10 working days** *N.B. 1st contact by the team may be by phone* | | |

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| **Service required:**  **Community**:  CNS Clinic  **Day Hospice:** 12-week Therapeutic programme  CNS Home visit  12-week Social Support  Hospice at Home  5 week Breathlessness programme  **Inpatient unit:  Medical Clinic appointment (Hospice)**: | |
| **Reasons for Referral:** Uncontrolled symptoms  Patient Emotional / psychosocial / spiritual support  Carer support  Terminal Care | |
| **This section MUST be completed**  Please describe the patient’s palliative care needs and any other significant information, including current medication and oxygen requirements, safeguarding or Mental Capacity concerns. For Blood Transfusions please speak to the Triage Nurse or refer for a medical outpatient clinic appointment at the Hospice. | |
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| **Advance Care Planning:**  ACP specific document in use: Yes  No  Current DNACPR or ReSPECT form in place? Yes  No  Comments: | Preferred place of care:  Preferred place of death *if different to preferred place of care*: |

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| **Allergies / Sensitivities:** | |  | |
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| **Insight:** | Has patient been told diagnosis? Yes  No | | Is the carer aware of patient’s prognosis? Yes  No |
|  | Is patient aware of prognosis? Yes  No | | Is the carer aware of patient’s referral? Yes  No  ***Please provide details in section above if any “No” responses*** |
|  | Does patient discuss the illness freely? Yes  No | |

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| **MOBILITY** | Independent  Mobile with aids  Wheelchair  Bed bound |
| **TRANSPORT** | Own transport/taxi  Ring and Ride  Transport required *(complete further info below)* |
| **Further information if transport required:** | Able to park outside house  Steps  Ramp  Rails  Incline |

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| ***Please ensure patients are aware information will be held on computer according to the Data Protection Act***  This form has been adapted from the SPAGG Adult Specialist Palliative Care Form. Both referral forms will be accepted by the charity. |

