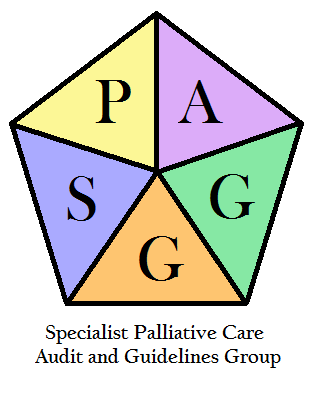
A picture containing text

Description automatically generated

**Adult Specialist Palliative Care (SPC) Referral Form**

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

|  |
| --- |
| **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. * Complex social needs resulting from their illness or whose families show exceptional emotional distress. * Has capacity & has consented to referral OR lacks capacity for this decision but it is agreed to be in their best interests |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient details** | | | | | | | | |
| **NHS Number:** | Patient consents to Specialist Palliative Care involvement: Yes  No  Unable | | | | *If No please give details on next page.* | | Office use | |
| Surname: | | Male / Female | | D.O.B: | | |
| First Name: | | | | Marital  Status: | | |
| Address: | | Ethnicity: | | | | |
|  | | Religion: | | | | |
| Postcode: | | Telephone: | | | | |
| Do they live alone? Yes No Add details if complex | | | | | | |
|  | | |  | | | | | |
| Referrer’s signature: | | | Name (please print): | | | | | |
| Job title: | | | Contact number: | | | | | Bleep No: |
| Surgery or Hospital: | | | | | | Date: | | |

|  |  |  |
| --- | --- | --- |
| **Next of kin/carer** | **District Nurse:** Involved Yes No | **General Practitioner:** |
| Name: | Name: | Name of Practice : |
| Relationship  to patient: | Based at: | Contact Number: |
| Telephone | Telephone: | Fax |
| Mobile: | Fax: | Email |
| **2Nd patient contact** | **Care Package:** Yes No | **Communication** |
| Name: | If yes how is it funded?  Private  CCG | Language if not English: |
| Relationship to patient |  | Communication in English  Good  Fair  Poor |
| Telephone: |  | Would an interpreter be helpful? Yes  No |
| Mobile: |  | Other barriers to communication, e.g. hearing loss, confusion: |
|  |  | |

Patient Name: ………………………………………………………NHS Number……………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Inpatient 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 | | | Key Team CNS/Contact: | |

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

|  |  |  |
| --- | --- | --- |
| **Brief history of diagnosis(es) and key treatments** | | |
| Date | Progression of disease and investigations/treatment | Consultant and hospital |
|  |  |  |
|  |  |  |
|  |  |  |
| **Estimated prognosis**: Days  Weeks  Months | | |

|  |  |  |
| --- | --- | --- |
| **Services patient would consider**  IPU Admission Community team  Living Well centre Hospice@Home  Physiotherapy Occupational therapy  Wellbeing Pharmacy  Paripassu pain clinic Acupuncture  Complementary Therapy FAB clinic  Patient & family coordinator | | **Advance Care Planning**  ACP specific document in useYes  No  Preferred place of care:  Preferred place of death if different:  Current DNACPR form in place? Yes  No  Comments: |
| **Reasons for Referral** Uncontrolled symptoms Patient Emotional / psychosocial / spiritual supportTerminal care  Carer support Other reason.eg. Lymphoedema. Please detail………………………………… | | |
| **Please detail below essential information needed by service to support care (or attach relevant documents):**   1. Details of symptom control advice/treatment already in place 2. All recent annotations/ clinic letters/investigation results 3. List of current medication and allergies or copy of patient summary care record 4. Any additional information which may be useful : | | |
|  | | |
| **Urgency of referral:** | **Within 2 working days** - **MUST** be accompanied by a telephone call from the referrer for immediate advice and to support level of urgency  **Within 5 working days  N.B. 1st contact by SPC team may be by phone.**  **Standard bereavement** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergies/ sensitivities** | |  | |
|  | | | |
| **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* ***Issues*** *section if any “No” responses* |
|  | Does patient discuss the illness freely? Yes  No | |

|  |
| --- |
| ***Please ensure patients are aware information will be held on computer according to the Data Protection Act*** |

Referral Form Manual – Specialist Palliative Care (June2016)