

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

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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.
* 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
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| **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: | MaritalStatus: |
| Address: | Ethnicity: |
|  | Religion: |
| Postcode: | Telephone: |
| Do they live alone? Yes[ ]  No[ ]  Add details if complex |
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| Referrer’s signature: | Name (please print): |
| Job title: | Contact number:  | Bleep No: |
| Surgery or Hospital: | Date: |

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| **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: |
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Patient Name: ………………………………………………………NHS Number……………………………

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| **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: |

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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 [ ]   |

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|  **Services patient would consider** IPU Admission Community teamLiving Well centre Hospice@HomePhysiotherapy Occupational therapyWellbeing PharmacyParipassu pain clinic AcupunctureComplementary Therapy FAB clinicPatient & 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 :
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| **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**  |

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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* ***Issues*** *section if any “No” responses*  |
|  | Does patient discuss the illness freely? Yes [ ]  No [ ]   |

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

Referral Form Manual – Specialist Palliative Care (June2016)