Specialist Palliative Care Referral Form

please ✓ **key service required**

☐ **Watford General Hospital – Inpatients**
Macmillan Palliative Care Team
Tel: 01923 217930
wherts-tr.pallativecare@nhs.net

☐ **Mount Vernon Cancer Centre**
Palliative Care Team
Tel: 0203 826 2392
hst.enh-tr@nhs.net
Mobile: 07825 034413

☐ **West Herts Specialist**
Palliative Care Referral Centre
For all palliative & EOL referrals
Tel: 0333 234 0868
Westherts.pcrc@nhs.net

PLEASE PHONE ABOUT URGENT REFERRALS *OUT OF HOURS ADVICE LINE 020 3826 2377*

We undertake to review your referral within 48 HOURS. We may wish to contact you for further clarification or to discuss the most appropriate plan of action for the patient.

SURNAME **Age** **DoB**	**Male** ☐ **Female** ☐
FIRST NAME **Known as**	**Marital Status**
ADDRESS **POSTCODE** **Email**	**PRIMARY DIAGNOSIS** **DATE of DIAGNOSIS**
HOME Tel **MOBILE Tel**	**NHS number**

MAIN CARER: **Relationship to patient** **Tel**		
NEXT of KIN (if different from above): **Relationship to patient** **Tel**		
Who does the patient live with? Main Language? Interpreter needed?		**Ethnicity** **Religion**
GP NAME **Is GP aware of referral? Yes/No**	**Tel** **Email**	**Surgery**
DISTRICT NURSE NAME	**Tel** **Email**	**Based at**
OTHER PALLIATIVE CARE SERVICE INVOLVED?	**Name of Specialist Nurse**	**Tel** **Email**
Who is the KEY WORKER?		**Continuing Care Assessment completed Yes/No**

Does the patient consent to their information being shared with other palliative care providers including Peace Hospice Care, Hospice of St Francis, Rennie Grove Hospice Care, Michael Sobell House and Herts Community NHS Trust? Yes/No

Has the patient consented to referral to Specialist Palliative Care? Yes/No If No, please complete mental capacity assessment and best interest documentation

Have any advance care planning discussions taken place? If yes, what outcomes

Is DNACPR completed? Yes/No **Is patient on EPaCCS? Yes/No**

BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS

Date	History, tests and treatment	Consultant and hospital

MRSA Status **C. Diff Status** **Other infection** **PATIENT MOBILITY**

PLEASE SEND COPIES OF RECENT CLINICAL LETTERS, HOLISTIC ASSESSMENT PAPERWORK, MENTAL CAPACITY ASSESSMENT, BEST INTEREST DECISION and DISTRESS THERMOMETER if completed

WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?

PLEASE SEND GP SUMMARY AND CURRENT MEDICATION LIST

Does the patient have pressure ulcers? Yes/No If Yes, specify grade

Main Reasons for Referral - *please* ✓

- **Pain control** ☐
- **Other symptom control (patient)** ☐
- **Emotional/psychological/spiritual support (patient)** ☐
- **Emotional/psychological/spiritual support (family/carer)** ☐
- **Social/financial support (patient)** ☐
- **Social/financial support (family/carer)** ☐
- **Rehabilitation** ☐
- **Respite Care** ☐
- **Discharge Planning** ☐
- **Other** ☐
- **Care in the last days of life** ☐

Service requested - *please* ✓ Subject to triage

- **Specialist Palliative Care at home/home assessment** ☐
- **Specialist Palliative Care Outpatient Assessment** ☐
- **Day Services /Wellbeing programmes**
  - *Grove House* St Albans ☐
  - *Spring Centre* Hospice of St Francis ☐
  - *Starlight Centre* Peace Hospice ☐
  - *Day Hospice* Michael Sobell House ☐
- **Hospice Admission** ☐

OACC - AKPS – please indicate percentage %

Phase of Illness – *please* ✓

☐ **Stable** ☐ **Unstable** ☐ **Deteriorating** ☐ **Dying** ☐ **Unknown**

The patient is currently – *please* ✓

- ☐ **Hospital (acute, community, other)**
- ☐ **Care home**
- ☐ **Patient's own home**
- ☐ **Hospice (inpatient specialist palliative care)**
- ☐ **Other residence (e.g. relative's home, carer's home)**
- ☐ **Other (free text, e.g. secure and detained settings)**

Hospital …… Ward …… Date of discharge…… Is Palliative Care team involved? Yes/No

REFERRER'S NAME …… CONTACT TELEPHONE NUMBER ……..

JOB TITLE ……..

Referrer's signature **DATE**