Specialist Palliative Care and Palliative Wellbeing Referral Form

please ✓ key service required

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

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

West Herts Out Of Hours Advice Line
Tel: 020 3826 2377

PLEASE ALSO PHONE REGARDING ALL URGENT REFERRALS

We undertake to review your referral within 48 HOURS.

We will contact you for further clarification or to discuss the most appropriate plan of action for the patient if required

SURNAME	**Male** ☐ **Female** ☐ **Other** ☐
FIRST NAME **Known as**	
ADDRESS **POSTCODE** **Email**	**PRIMARY DIAGNOSIS** **DATE of DIAGNOSIS**
HOME Tel **MOBILE Tel**	**NHS number** **DOB**

MAIN CARER: **Relationship to patient** **Tel:**	**NEXT of KIN** (if different): **Relationship to patient** **Tel:**

Who does the patient live with? Main Language? Interpreter needed? Yes/No Religion Ethnicity		***Mental Health needs Yes/No*** ***Learning disability Yes/No*** ***Please provide additional information with referral***
GP NAME **Is GP aware of referral? Yes/No**	**Tel** **Email**	**Surgery Name**
DISTRICT NURSE involved Y / N	**KNOWN TO**	**Based at**
Name of other Specialist Service involved	**Name of staff member**	**Tel**

Funding for care approved : Yes /No **If in progress please forward application paperwork**

Approval for: Fast Track CHC (Nursing Home) ☐ **Rapid Personalised Care Service RPCS (Home)** ☐ **Social care** ☐

Does the patient have capacity to make decisions Yes/No

If No, please complete Mental capacity assessment and Best interest documentation

Has the patient consented to referral to Specialist Palliative Care Yes/No

Does the patient have LPA: Health Yes /No Finance Yes/No Further information:

Have any advance care planning discussions been offered? Yes/No

Have any advance care planning discussions taken place? Yes/No

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** | **MOBILITY**

PLEASE SEND COPIES OF ALL 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?

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

OACC - AKPS (please indicate percentage) ……. %

Phase of Illness – *please* ✓ ☐ Stable ☐ Unstable ☐ Deteriorating ☐ Dying ☐ Unknown

Rockwood Frailty Scale Score: …… ☐ Unknown

Main Reasons for Referral - *please* ✓		**Service requested - *please* ✓ Subject to triage**	
Care in the last days of life	☐	**Hospice Admission**	☐
Symptom control	☐	**Community Palliative Care**	☐
Emotional/psychological/spiritual support (patient)	☐	**Can patient attend clinic**	**Yes/No**
Emotional/psychological/spiritual support (family/carer)	☐		
Social/financial support (patient)	☐	**Specialist Palliative Care Outpatient Assessment**	
Social/financial support (family/carer)	☐	**Day Services /Wellbeing services**	
Rehabilitation	☐	*Grove House* Rennie Grove Hospice Care	☐
Other	☐	*Spring Centre* Hospice of St Francis	☐
		Starlight Centre Peace Hospice	☐

The patient is currently ; (eg Hospital/Home)

☐ **If in Hospital Name:** **Hospital Ward:** **Date of Discharge:**

REFERRER'S NAME **JOB TITLE**

CONTACT NUMBER:

Referrer's signature: Date:

PLEASE ATTACH CLINIC LETTERS, CURRENT MEDICATION AND PATIENT SUMMARY