**Referral Form**

**Please ring 01207 529224 for any queries**

**Please complete this form in full**

**\*\*\* NB. Please determine that GP cover is agreed to cover for visits following admission & duration of the patient stay prior to submission of the referral.**

**Please phone to make staff aware of the referral if urgent- please return to Willowburnhospice.referrals@nhs.net**

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| **Service Required**  In Patient Care \*  Day Hospice Service  \*Is the patient/family fully aware of the reason for referral & anticipated length of stay?  🞎 Yes 🞎 No | | | **Planned date of admission**  / /  **Reason for referral to Inpatient Services:**  \*Symptom control 🞎  \* End of life care 🞎  \*Crisis intervention 🞎  Respite (planned admission ) 🞎 | | **Referral agreed with:**  Patient  Relative  District Nurse  GP  Hospital Consultant | |
| **Referral Date:** | | | | **Referred by:**  **Designation:**  **Contact Number:**  **E -mail address:** | | |
| **Title:** | | **Name:**  **DOB:**  **NHS no:**  **Gender: M / F Ethnicity:** | |
| **Address:**  **Postcode:**  **Tel No(s):** | | | |
| **Carer/NOK-1:** | | | |  | | |
| **Address:**  **Tel No:**  **Relationship:**  **Care/NOK-2:**  **Address:**  **Tel No:**  **Relationship:** | | | | **GP:**  **Surgery**  **Tel no:**  **District Nurse:**  **Tel No:**  **Specialist Nurse:**  **Tel No:**  **Hospital Consultants:**  **Tel No:**  **Social Worker:**  **Tel No:**  **Care Agency:**  **Tel No:** | | |
| **Diagnosis:**  **Past Medical History:**  **Known allergies:**  **Is patient MRSA positive?** 🞎 Yes 🞎 No  **Any other infections?** 🞎 Yes 🞎 No  Please provide details:  April 2020 **COVID 19 test date/result**:( please arrange prior to admission if not completed-state details) | | | |
| **Treatment to date: please tick all which apply**   * Chemotherapy * Radiotherapy * Has been/ Currently on syringe driver * Recent blood transfusion * Other (details)…………………………………………..   **Current medication summary- drug/dose/frequency**  **Does the patient self- medicate?** Yes 🞎 No 🞎  **Alternative drug/feeding administration route/equipment used? eg PEG/Duodopa/Omnipod/Syringe driver etc.**  **(Please state/detail):**  **Does patient have any arranged follow-up appointments?** 🞎 Yes 🞎 No (if yes please provide details)  **Current summary of patient symptoms/management:**  Does the patient have: if Yes please provide details if No please provide details of discussion regarding this:  **DNACPR:**  🞎 Yes 🞎 No  Details  **EHCP:** 🞎 Yes 🞎 No  Details:  **ADRT:** 🞎 Yes 🞎 No  Details:  **LPA for health & welfare:** 🞎 Yes 🞎 No **LPA for property & finance:** 🞎 Yes 🞎 No  Details:(name & relationship of named attorney) | | | | |
| **Current Physical, Emotional and Mental Health Needs:**  **Mobility:** independent 🞎 Transfers with assistance 🞎 Zimmer-frame/stick 🞎 Stand aid 🞎 Hoist 🞎  **Nutritional status/dietary needs: eg. PEG/SALT**  **Bariatric patient? :** 🞎 Yes 🞎 No Current weight: lbs/Kg BMI:  **Does patient require O2? \*Please order/arrange oxygen concentrator for patient’s arrival when admission confirmed( this needs to be completed by the referrer as current prescription information will be required)**  🞎 Yes 🞎 No Number of litres: 🞎 mask 🞎 nasal cannula  **Continence needs:**  **Does patient suffer from nausea/vomiting?:** 🞎 Yes 🞎 No (if yes, please give details of current status & management)  **Current emotional state:**  **Does patient suffer from any mental health condition/ recurrent confusion/memory impairment etc? :**  **Does the patient have a diagnosis of Dementia? Yes** 🞎 **No** 🞎  **Are there any Adult Safeguarding concerns/mental capacity concerns/any arrangements/ DoLS in place?**  **Yes** 🞎 **No** 🞎  **-Please provide details(copies of any documentation will be required on admission):** | | | | |
| **Social Circumstances ( where appropriate please provide additional details)**  **Does patient live alone?** 🞎 Yes 🞎 No  **Type of property (house, bungalow, flat etc.):**  **Are any care agencies currently involved?** 🞎 Yes 🞎 No **Care package outline:**  **Family Support- please outline family (Genogram) & friends/involvement etc.**  **Are there any family dynamics that staff should be made aware of?** 🞎 Yes 🞎 No **(Please provide details)**:  **Additional Information-(please include anything which may be relevant in assessing the referral in order to prioritise & enable us to agree appropriate placement where we are able to plan care to meet the patient’s & family needs fully):** | | | | |

**Please forward completed form to**

[**Willowburnhospice.referrals@nhs.net**](mailto:Willowburnhospice.referrals@nhs.net)