**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 RelativeDistrict NurseGPHospital 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 🞎 NoPlease 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 🞎 NoDetails**EHCP:** 🞎 Yes 🞎 NoDetails:**ADRT:** 🞎 Yes 🞎 NoDetails:**LPA for health & welfare:** 🞎 Yes 🞎 No **LPA for property & finance:** 🞎 Yes 🞎 NoDetails:(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**