**Specialist Palliative Care Referral Form**

**NB This form can be largely auto completed on SystmOne or Ardens**

 [ ] **Community Palliative Care Referral Centre** [ ]  **Lister Hospital Palliative Care Team**

* ***Garden House Hospice Care***
* ***Isabel Hospice***  Tel: 01438 284035/07503 760801
* ***HCT Specialist Palliative*** ***Care CNS Team:*** palliativecareteam.enh-tr@nhs.net

Tel: 0300 123 7571 Option 2

 Nhadmin.palliativecare@nhs.net

**PLEASE PHONE ABOUT ALL URGENT REFERRALS**

**We aim to respond to your referral within 24 HOURS. We may need to contact you for additional information. To avoid delay please ensure the patient has consented to the referral.**

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| **Surname DoB**  | **Male** [ ]  **Female** [ ]  |
| **First name**  | **NHS number**  |
| **Address** **Postcode**  | **Primary diagnosis** |
| **Home Tel Mobile Tel** | **GP Surgery** |
| **Main language****Communication needs eg Interpreter needed. Any reasonable adjustments required?** |
| **Main carer/next of kin** **Relationship to patient Tel** **Relationship to patient:** **Mobile tel**  |
| **Does the patient consent to their information being shared for the purposes of this referral? Yes/No** **Has the patient consented to referral to Specialist Palliative Care? Yes/No**  |
| **Brief history of current illness and key treatments:** |
| Date | History, tests and treatment | Consultant and hospital |
|  |  |  |
| **Any known infection risk**   |
| **Please send copies of relevant documents including recent clinical letters, GP summary, iPOS, holistic assessment, mental capacity assessment and best interests decision where available.****completed** |
| **What are the key concerns of the patient/family/carer that require specialist palliative care input?** |
| **Specialist Palliative Care service requested****Community CNS assessment in Clinic** [ ] **Community CNS assessment at home/remotely (if unable to get to clinic)** [ ] **Hospice Services****Rehabilitation/Living Well/Outpatients** [ ] **Hospice at Home** [ ] **Family Support/Counselling** [ ] **Hospice In-Patient Unit Admission for symptom control or last days of life care** [ ] **Hospital in-patient assessment** [ ]  |

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| **Patient’s current location –** *please tick appropriate box* |
| [ ]  **Hospital (acute, community, other)**Ward Date of discharge Palliative Care team involved? Yes/No[ ]  **Patient’s own home** [ ]  **Other residence (e.g. relative’s home, carer’s home)** [ ]  **Care home**[ ]  **Hospice (in-patient specialist palliative care)**[ ]  **Other (free text, e.g. secure and detained settings)**  |

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| **Referrer’s name Job title Tel no** **Referrer’s signature** **Date**  |
| **NB Please open a shared patient record on SystmOne at time of referral.** |