**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](mailto:palliativecareteam.enh-tr@nhs.net)

Tel: 0300 123 7571 Option 2

[Nhadmin.palliativecare@nhs.net](mailto: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.**

|  |  |  |  |
| --- | --- | --- | --- |
| **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** | | | |

|  |
| --- |
| **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)** |

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