

Rapid Personalised Care Service

REFERRAL FORM

Referral Criteria

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| 1. | Patient has a diagnosis entering the terminal stages. |
| 2. | Patient has a poor prognosis likely to be less than 12 weeks, they have an irreversible condition that no longer responds to medical treatment/ intervention, DNAR in place. |
| 3. | Patient is rapidly deteriorating and requires urgent care services. |
| 4. | Patient must be registered with Herts Valleys GP |

**Send all completed referrals to the following email address** [**westherts.RPCS@NHS.Net**](mailto:westherts.RPCS@NHS.Net) **along with all the relevant evidence.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** |  | **Date of referral:** |  |
| **Referrer contact details:** |  | **Referrer location:** |  |

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| --- | --- | --- | --- |
| **Patient’s Details** | | | |
| **Patients Full Name:** |  | **Title:** |  |
| **Preferred Name:** |  | **DOB:** |  |
| **NHS Number:** |  | **GP Name:** |  |
| **Ethnicity:** |  | **Religion: Spiritual/cultural Care needs:** |  |
| **Preferred language:** |  | **Gender:** |  |
| **Patients Address and Postcode:** |  | **Home No:** |  |
| **Mobile No:** |  |
| **Email address:** |  | | |

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| **EOLC DETAILS** | |
| **PRIMARY DIAGNOSIS AND DATE:** |  |
| **SITE and details OF ANY SECONDARY SPREAD:** |  |
| **IS THERE A DNACPR IN PLACE?** |  |
| **Is the patient for any further active treatment and hospital admission?** |  |
| **PAST MEDICAL HISTORY:** |  |
| **HEALTH CARE PROFESSIONALS INVOLVED.**  **Consultant, palliative care team, community nurse etc** |  |
| **EOL WISHES INCL PPC/PPD:** |  |

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| **I believe this person has a rapidly deteriorating condition and they may be entering the terminal phase of their illness because:**  **AKPS / IPOS:** |  | |
| **Pain and symptom management:** |  | |
| **Mobility; Identify Aids In Place / Lifting And Handling Issues / Transfers:** |  | |
| **PERSONAL CARE REQUIREMENTS?**  **ASSISTANCE OF HOW MANY?** |  | |
| **Communication:** |  | |
| **Cognition:** |  | |
| **Psychological / Well Being :** |  | |
| **Elimination – Include Continence Products / Aids:** |  | |
| **Skin Integrity – Highlight actions to take/equipment in place:** |  | |
|  |  | **If Yes, please specify:** |
| **Is the patient at high risk of falls?** | **Yes / No** |  |
| **Does the patient have any pressure ulcers** | **Yes / No** | **If yes please state grade and if datx/incident form completed + date** |
| **Does the patient require any special diet** | **Yes / No** |  |

**Package of Care required (please tick):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Req’d?** | **Details of what will be required** | | | | |
| District Nursing |  |  | | | | |
| Palliative care Nurse |  |  | | | | |
|  | | | | | | |
|  |  | Please tick what is required | | | | **Details of what will be required** |
|  |  | **AM** | **LT** | **TT** | **PM** |  |
| Single carer |  |  |  |  |  |  |
| Double up |  |  |  |  |  |  |

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| **Does the patient require support with any of the following (please tick):** | | | | |
| Washing, dressing |  |  | Meal / drink preparation |  |
| Toileting |  |  | Medication |  |
| Rota stand |  |  | Hoist |  |

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Skin Care / regular checks

Wound care give full details above

Assistance when mobilising

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| **Relationships** | | | |
| **Next of Kin Name and relationship to patient:** |  | | |
| **Details of other significant relationships:** |  | | |
| **Does patient live alone?** | Yes / No Who will be there at night time? | | |
| **Is there a Telecare line/ life line in the home?** |  | | |
| **Accommodation type:** |  | | |
| **Who will let the carers in?** |  | **Key safe?** |  |
| **Any pets in the property?** |  | | |

**Please note we are a non-gender / non time specific service**

**Our visit times are usually between:**

Morning - 8am and 11am

Lunchtime - 12pm and 2.30pm

Teatime - 3.30pm and 6pm

Bedtime – 6.30pm and 10pm