**Telephone: 01296 332608 Email:** **buc-tr.fnhspa@nhs.net** **PAGE 1 of 2**

**BUCKINGHAMSHIRE PALLIATIVE CARE REFERRAL FORM**

**via SINGLE POINT OF ACCESS - FINAL VERSION 11.06.2018**

**(Please ensure that ALL parts of this form are completed in FULL before submitting to SPA)**

**If referral form is incomplete it will be returned for further information and no action**

**will be taken until it is returned successfully completed.**

|  |  |
| --- | --- |
| **SURNAME Age DoB**  | **Male** [ ]  **Female** [ ]  |
| **FIRST NAME Known as**  | **Marital Status**  |
| **ADDRESS** **POSTCODE** **Email** | **PRIMARY DIAGNOSIS** **DATE of DIAGNOSIS****DATE of REFERRAL** |
| **HOME Tel** **MOBILE Tel**  | **NHS number**  |
| **MAIN CARER:****Relationship to patient**  T**el**  |
| **NEXT of KIN (**if different from above): **Relationship to patient**  **Tel**  |
| **Who does the patient live with?**Main Language? Interpreter needed?  | **Ethnicity****Religion** |
| **GP NAME****Is GP aware of referral? Yes/No** | **Tel** **Email** | **Surgery**  |
| **KNOWN TO DISTRICT NURSE? Yes/No** | **Tel** **Email** | **Based at** |
| **OTHER PALLIATIVE CARE SERVICE INVOLVED?**  | **Name of Specialist Nurse** | **Tel** **Email** |
| **Patient aware of diagnosis? Yes/No** **Family aware of diagnosis?** **Yes/No** | **Continuing Care Assessment completed**  **Yes / No / Don’t know** |
| **Does the patient consent to their information being shared with other palliative and healthcare providers? Yes/No****Has the patient consented to referral to Specialist Palliative Care? Yes/No** **Is this a best interest decision? Yes/No**  |
| **Have any advance care planning discussions taken place? If yes, what outcomes** **Is DNACPR completed? Yes/No** **Does the patient have an Advance Care Plan (as part of Bucks CCGS primary care EoL scheme?)****Has the patient consented to record sharing through Summary Care Record Additional (SCR+)** |
| **Current location of patient – *please* 🗸** |
| [ ]  **Hospital (acute, community, other)** [ ]  **Hospice (inpatient specialist palliative care)** [ ]  **Care home** [ ]  **Other residence (e.g. relative’s home, carer’s home)** [ ]  **Patient’s own home** [ ]  **Other (free text, e.g. secure and detained settings)**  |

**Specialist Palliative Care Referral Form PAGE 2 of 2**

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| --- |
| **BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS**  |
| Date | History, tests and treatment | Consultant and hospital |
|  |  |  |
| **MRSA Status C. Diff Status Other infection**  | **PATIENT MOBILITY**  |
| **WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?****PRIORITY OF RESPONSE (Please delete as appropriate): URGENT SOON ROUTINE****PLEASE SEND GP SUMMARY, COPIES OF RECENT CLINICAL LETTERS AND CURRENT MEDICATION LIST** |
| **Does the patient have pressure ulcers? Yes/No If Yes, specify grade** |
| **Main Reasons for Referral - *please* ✓** | **Service requested - *please* ✓**  | **Provider requested - *please* ✓**  |
| **Symptom control**  | [ ]  | **Hospice Admission** | [ ]  | **FNH** | [ ]  |
| **Medical intervention e.g transfusion**  | [ ]  | **Community Team**  | [ ]  | **FNH Hospice@Home**  | [ ]  |
| **Psychological support**  | [ ]  | **Day Hospice**  | [ ]  | **South Bucks CNS Team** | [ ]  |
| **End of Life Care**  | [ ]  | **Lymphoedema** | [ ]  | **Rennie Grove Hospice at Home** (South Bucks / Wycombe / Ridgeway) | [ ]  |
| **Respite** | [ ]  | **Physio / OT** | [ ]  | **South Bucks Community Hospice** | [ ]  |
| **Other (please specify)** | [ ]  | **Medical OP / DV** | [ ]  | **Sue Ryder Nettlebed Hospice** | [ ]  |
|  |  | **Hospital Team** | [ ]  | **Hospice of St Francis** | [ ]  |
|  |  | **Breathwell Group (DWP)** | [ ]  | **Thames Hospice**  | [ ]  |
|  |  | **In reach team** | [ ]  | **Bucks Hospitals Teams** | [ ]  |
|  |  |  |  | **Marie Curie (alternative form required)** | [ ]  |
| **PREFERRED PLACE OF CARE / DEATH: Home / Hospice / Hospital / Unknown / Other (Please specify)** |
| **REFERRER DETAILS** |
| **Name:****(Please print)** |  | **Routine Telephone No:** |  |
| **Job Title:** |  | **Priority Contact No** (for a **minimum** of **2 hours** following **ANY Urgent** Referral being made via SPA)**:** |  |
| **Organisation:**  |  | **E-mail address (to ensure you receive confirmation of your referral):** |  |
| **Already Discussed Referral with Provider? Yes / No** |
| **Details of discussion:** |

**Final Version 11.06.2018**