**Specialist Palliative Care and Palliative Wellbeing Referral Form** ***please* ✓ key service required** **PAGE 1 of 2**

 [ ]  **Watford General Hospital Inpatients** **[ ]  West Herts Specialist West Herts Out Of Hours**

 **Macmillan Palliative Care Team Palliative Care Referral Centre Advice Line**

 Tel: 01923 217930 **All palliative & EOL referrals** Tel: 020 3826 2377

 wherts-tr.pallativecare@nhs.net Tel: 0333 234 0868

 Westherts.pcrc@nhs.net

 ***PLEASE ALSO PHONE REGARDING ALL URGENT REFERRALS***

***We undertake to review your referral within 48 HOURS.***

***We will contact you for further clarification or to discuss the most appropriate plan of action for the patient if required***

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| **SURNAME**  | **Male** [ ]  **Female** [ ]  **Other** [ ]  |
| **FIRST NAME Known as** |  |
| **ADDRESS** **POSTCODE** **Email** | **PRIMARY DIAGNOSIS** **DATE of DIAGNOSIS** |
| **HOME Tel** **MOBILE Tel**  | **NHS number****DOB**  |

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| **MAIN CARER:****Relationship to patient**  T**el:**  | **NEXT of KIN** (if different): **Relationship to patient** **Tel:**  |
| **Who does the patient live with?**Main Language? Interpreter needed? Yes/NoReligionEthnicity | ***Mental Health needs Yes/No******Learning disability Yes/No*** ***Please provide additional information with referral***  |
| **GP NAME****Is GP aware of referral? Yes/No** | **Tel** **Email** | **Surgery Name**  |
| **DISTRICT NURSE involved Y / N** | **KNOWN TO**  | **Based at** |
| **Name of other Specialist Service involved**  | **Name of staff member** | **Tel** **Email** |
| **Funding for care approved : Yes /No If in progress please forward application paperwork** **Approval for: Fast Track CHC (Nursing Home)** [ ]  **Rapid Personalised Care Service RPCS (Home)** [ ]  **Social care** [ ]  |
| **Does the patient have capacity to make decisions Yes/No****If No, please complete Mental capacity assessment and Best interest documentation****Has the patient consented to referral to Specialist Palliative Care Yes/No** **Does the patient have LPA: Health Yes /No Finance Yes/No Further information:** |
| **Have any advance care planning discussions been offered? Yes/No** **Have any advance care planning discussions taken place? Yes/No****If yes, what outcomes:** **Is DNACPR completed? Yes/No Is patient on EPaCCS? Yes/No** |

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| **BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS**  |
| Date | History, tests and treatment | Consultant and hospital |
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| **MRSA Status C. Diff Status Other infection**  | **MOBILITY**  |
| **PLEASE SEND COPIES OF ALL RECENT CLINICAL LETTERS, HOLISTIC ASSESSMENT PAPERWORK, MENTAL CAPACITY ASSESSMENT, BEST INTEREST DECISION and DISTRESS THERMOMETER if completed** |
| **WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?** |
| **Does the patient have pressure ulcers? Yes/No If Yes, specify grade** |
|  **OACC - AKPS (please indicate percentage) ….... %**  **Phase of Illness – *please* 🗸** [ ]  **Stable** [ ]  **Unstable** [ ]  **Deteriorating** [ ]  **Dying** [ ]  **Unknown**  **Rockwood Frailty Scale Score: …………** [ ]  **Unknown**  |
| **Main Reasons for Referral - *please* ✓** | **Service requested - *please* ✓ Subject to triage** |
|  **Care in the last days of life** [ ]  **Symptom control ☐****Emotional/psychological/spiritual support (patient)** [ ] **Emotional/psychological/spiritual support (family/carer)** [ ] **Social/financial support (patient)** [ ] **Social/financial support (family/carer)** [ ] **Rehabilitation** [ ] **Other** [ ]  | **Hospice Admission** [ ]  **Community Palliative Care** [ ] **Can patient attend clinic Yes/No****Specialist Palliative Care Outpatient Assessment**  **Day Services /Wellbeing services***Grove House* Rennie Grove Hospice Care [ ]  *Spring Centre* Hospice of St Francis [ ] *Starlight Centre* Peace Hospice [ ]   |
| **The patient is currently ; ( eg Hospital/Home)**  |
| **☐ If in Hospital Name: Hospital Ward: Date of Discharge:** |
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| **REFERRER’S NAME JOB TITLE** **CONTACT NUMBER:** **Referrer’s signature:** Date:  |

**PLEASE ATTACH CLINIC LETTERS, CURRENT MEDICATION AND PATIENT SUMMARY** |