**Telephone: 01296 321341 Email:** [**buc-tr.fnhspa@nhs.net**](mailto: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**  **39** | | **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+)** | | | |
|  | | | |
| **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**

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