**Specialist Palliative Care and Palliative Wellbeing Referral Form** ***please* ü key service required**

**Watford General Hospital Inpatients**  **West Herts Specialist 24 Hour Specialist Palliative Care**

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

[**Tel:01923**](Tel:01923) **217930 (PCRC)** [**Tel: 01923**](Tel:01923) **335356**

[westherts.palliativecare@nhs.net](mailto:westherts.palliativecare@nhs.net) **Tel: 03000200656 #2 #0**

[westherts.pcrc@nhs.net](mailto:Westherts.pcrc@nhs.net)

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

***Referrals received after 4pm will be triaged following day if not phoned through as URGENT***

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

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

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| **PATIENT DETAILS** | | | | | | | | | |
| **SURNAME:** | |  | | | | | **GENDER:** | |  |
| **FIRST NAME:** | |  | | | | | **KNOWN AS:** | |  |
| **DATE OF BIRTH:** | |  | | | | | **NHS No:** | |  |
| **ETHNICITY:** | |  | | | | | **RELIGION:** | |  |
| **MAIN LANGUAGE:** | |  | | | | | **INTERPRETER REQUIRED YES/ NO** | | |
| **ADDRESS:**  **POSTCODE:** | |  | | | | | **HOME TEL:**  **MOBILE TEL:**  **EMAIL:** | |  |
| **PRIMARY DIAGNOSIS:**  **DATE OF DIAGNOSIS:** | |  | | | | | | | |
| **MENTAL HEALTH NEEDS:**  **LEARNING DISABILITY:**  **KNOWN SAFEGUARDING CONCERNS:**  **REASONABLE ADJUSTMENTS:** | | *If t please provide additional information:* | | | | | | | |
| **MAIN CARER / NOK INFORMATION** | | | | | | | | | |
| **MAIN CARER:**  **Relationship to patient:**  **Tel:** | | | | | **NEXT OF KIN** *(if different):*  **Relationship to patient:**  **Tel:** | | | | |
| **WHO DOES THE PATIENT LIVE WITH?** | | | | | **MAIN LANGUAGE:**  **INTERPRETER REQUIRED** Yes □ / No | | | | |
| **GP SURGERY:**  **TEL:**  **EMAIL:** | | | | | **GP NAME:**  **IS GP AWARE OF REFERRAL** Yes □ / No □ | | | | |
| **REFERRAL DETAILS** | | | | | **DATE OF REFERRAL:** | | | | |
| **HAS THE PATIENT CONSENTED TO THIS REFERRAL** Yes | | | | | | | | | |
| **DOES THE PATIENT HAVE CAPACITY TO CONSENT TO THIS REFERRAL?** Yes/No  **If ‘No’ please complete the section at the end of this form summarising discussions you have had supporting a Best Interest Decision, or attach a completed ‘Hertfordshire multi agency mental capacity  assessment and best interest form’.**  **PLEASE NOTE: Requests for hospice admission can only be considered where the patient has consented to the referral or there is documentation supporting a Best Interest Decision.** | | | | | | | | | |
| **SERVICE REQUESTED:** | | | | | | | | | |
| □ HOSPICE **ADMISSION:** | | | Please tick to indicate which Hospice(s) the patient would be happy to accept:  □ Hospice of St Francis □ Peace Hospice □ Either  Is patient on Oxygen Yes □ / No □  If yes: …….… l / per min or □ Not Known | | | | | | |
| □ COMMUNITY **PALLIATIVE CARE (AT HOME)** | | |  | | | | | | |
| □ SPECIALIST **PALLIATIVE CARE OUTPATIENT ASSESSMENT** | | | Can the patient attend clinic?  □ *Spring Centre* □ *Starlight Centre*  □ *Grove House* | | | | | | |
| □ **DAY SERVICES /WELLBEING SERVICES** | | | □ *Spring Centre* □ *Starlight Centre*  □ Compassionate neighbour (*W3R/Hertsmere only*) | | | | | | |
| **MAIN REASON FOR REFERRAL** – please advise the key concerns that require specialist palliative care input in the space below. | | | | | | | | | |
| **□ CARE IN THE LAST DAYS OF LIFE** | | |  | | | | | | |
| □ **SYMPTOM CONTROL** | | |  | | | | | | |
| □ **EMOTIONAL/PSYCHOLOGICAL/SPIRITUAL SUPPORT** | | | □ Patient  □ Family/carer | | | | | | |
| □ **SOCIAL/FINANCIAL SUPPORT** | | | □ Patient  □ Family/carer | | | | | | |
| □ **REHABILITATION** | | |  | | | | | | |
| □ **OTHER - any additional information** | | |  | | | | | | |
| **Have any advance care planning discussions been offered/taken place?** | | | Yes □ / No □  . | | | | | | |
| **Outcome of advance care planning discussions** | | | Further information of advance care discussions:  Has a Respect form been completed? Yes / No □  Has a DNACPR been completed? Yes / No □  Is patient on EPaCCS? Yes / No □  Is there an ADRT? Yes / No □ | | | | | | |
| **Does the patient have an LPA for:** | | | Health: No □ / Not known □  Finance: No □ / Not known □  Further Information: | | | | | | |
| **Has the patient been prescribed Anticipatory Medication:** Yes □ / No □  **Has an Anticipatory Medication Chart been issued:** Yes □ / No □ | | | | | | | | | |
|  | | | | | | | | | |
| **DISTRICT NURSE INVOLVED** Yes □ / No □ | | | | | | | | | |
| **Known to:** |  | | | | | **Based at:** | |  | |
| **OTHER SPECIALIST SERVICE INVOLVED** Yes □ / No □ | | | | | | | | | |
| **Name of service and staff member:** | | | | **Tel:** | | | | **Email** | |
|  | | | |  | | | |  | |
| **Funding for care approved:** Yes □ / No □ **/** Notknown□  **Approval for (if known):**  **Fast Track CHC (Nursing Home) ☐ Rapid Personalised Care Service RPCS (Home) ☐ Social care ☐** | | | | | | | | | |

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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:** | | | **MOBILITY** | |
| **Does the patient have pressure ulcers? Yes**  No □ **/** Not known **□ If YES Category: Reported:** Yes □ / No □ | | | | |
| **OACC - AKPS (if known please indicate percentage): %**  **Phase of Illness – *please* P** ☐ Stable ☐ Unstable ☐ Deteriorating ☐ Dying ☐ Unknown  **Rockwood Frailty Scale Score: GSF Score: ­** | | | | |
| **The patient is currently: □ At home □ In hospital □ Other location** | | | | |
| **□ Hospital name: Hospital Ward: Date of Discharge:**  **□ If Other location, please provide details of current accommodation including contact name and telephone number:** | | | | |
| **REFERRER’S NAME: JOB TITLE:**    **REFERRER’S SIGNATURE:** **DATE:** **CONTACT NUMBER:** | | | | |
| **PLEASE ATTACH CLINIC LETTERS, INVESTIGATIONS, CURRENT MEDICATION AND PATIENT SUMMARY.**  **IF COMPLETED PLEASE ATTACH:**  □ Mental Capacity Assessment □ Best Interest Decision □ CHC application □ Distress Thermometer □ ReSPECT form □ ACP/ADRT | | | | |
|  | | | | |
| **SUMMARY OF DISCUSSION SUPPORTING BEST INTEREST DECISION** | | | | |
| Please advise the name and position of the individual who completed this summary:  Name: Role: | | | | |
| Is the patient likely to regain capacity? | | Yes □ / No □ / Not known □ | | |
| What arrangements have you made to ensure that as far as practicable the person is helped to participate as fully as possible in the decision making | |  | | |
| What are the person’s past and present wishes?  (If there are any relevant forms, e.g. ReSPECT, DNACPR, ACP, ADRT, please attach a copy). | | Is there an advance decision? Yes □ / No □  If yes and it is valid and applicable to the decision please attach a copy.  Have any advance care planning discussions taken place? Yes □ / No □  If yes, what outcomes:  Has a ReSPECT form been completed Yes □ / No □  Has a DNACPR been completed? Yes □ / No □  Is patient on EPaCCS? Yes □ / No □  Is there an ADRT? Yes □ / No □ | | |
| What are the person’s beliefs and values that would be likely to influence their decision? | |  | | |
| What other factors would they consider? | |  | | |
| What are the views of significant others? | | Identify those consulted, their relationship to the patient and whether they have LPA:  Does the patient have an LPA Health and Wellbeing Yes □ / No □ / Not known □  Further information:  Does the patient have an LPA Finance Yes □ / No □ / Not known □  Further information: | | |
| Summarise the decision made and why it is in the patient's best interests. | |  | | |