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

 westherts.palliativecare@nhs.net **Tel: 03000200656 #2 #0**

 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 □ EitherIs 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** |
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| **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. |  |