

**Joint Referral Form for Supportive,**

**Palliative and End of Life Care**

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| **Date/Time:** |  | | | | **ick box if "yes" below)** | | | | | | | | | |
| Triage: Please tick appropriate box(s) below: | | | | | | | | | | | | | | |
| Urgent  (2-4hrs) | | | | | | | Routine  (as per waiting list) | | | | | | | |
| Consent and **Knowledge**: | | | | | | | | | | | | | | |
|  | | Diagnosis: (yes/no) | | | | | | Prognosis: (yes/no) | | | | | Referral: (yes/no) | |
| Is the patient aware of? | |  | | | | | |  | | | | |  | |
| Is the Main Carer aware of? | |  | | | | | |  | | | | |  | |
| **Patient Details:** | | | | | | | | | | | | | | |
| Patient Name:  Likes to called:  Address:  Postcode: | | | | | | | NHS No: | | |  | | | | |
| Gender: | | |  | | | | |
| DoB: | | |  | | | | |
| Age: | | |  | | | | |
| Contact Numbers  Home:  Mobile:  Contact: | | | | | | | Ethnicity: | | |  | | | | |
| Religion: | | |  | | | | |
| Patient’s First Language: | | |  | | | | |
| Current or previous Occupation: | | |  | | | | |
| Currently residing at (if different from above):  Address:  Postcode:  Contact Number: | | | | | | | | Location of Key Safe, if applicable:  Key Safe Number:  Does the patient live alone? YES  NO | | | | | | |
| Main Carer/Parent Details: | | | | | | | Sibling Details *(for Children’s Services)*: | | | | | | | |
| Full Name:  Please state the relationship to the Patient:  Address:  Postcode:  Main Contact Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Next of Kin:  Relationship:    Contact Number: | | | | | | | List Sibling Names and Dates of Birth, if applicable: | | | | | | | |
| Name(s) | | | | | Date of Birth(s) | | |
|  | | | | |  | | |
| **Patient Medical Information:** | | | | | | | | | | | | | | |
| **Primary Diagnosis of Patient:**  **Past Medical History and Presenting Condition of Patient:**  **Current Medications:** | | | | | | | | | | | | | | |
|  | | | | | | | | **Yes: Further details** | | | | | No | |
| Are there any other health conditions? | | | | | | | |  | | | | |  | |
| Are there any allergies? | | | | | | | |  | | | | |  | |
| Does the patient have ReSPECT form? | | | | | | | |  | | | | |  | |
| Does the patient have a DNACPR in place? | | | | | | | |  | | | | |  | |
| Has an advance care plan been completed? | | | | | | | |  | | | | |  | |
| Are anticipatory medications prescribed? | | | | | | | |  | | | | |  | |
| Has the patient got a signed Advance Decision to Refuse Treatment (ADRT)? | | | | | | | |  | | | | |  | |
| Are there any communication problems? | | | | | | | |  | | | | |  | |
| Have there been any concerns regarding decision making? | | | | | | | |  | | | | |  | |
| Is there any challenging behavior? | | | | | | | |  | | | | |  | |
| Is the patient mobile? | | | | | | | |  | | | | |  | |
| Please tick which service(s) you would like your referral to be forwarded to: | | | | | | | | | | | | | | |
| Macmillan Palliative Care Team  Welfare & Benefits  Spiritual  Family Support  Haven Team  St Andrews Hospice  Living With and Beyond Cancer Team | | | | | | | | | | | | | | |
| **Reason for Referral: Please provide additional information** | | | | | | | | | | | | | | |
| Physical/Symptom Management: | |  | | | | | | | | | | | | |
| Psychological/Emotional: | |  | | | | | | | | | | | | |
| Religious/Spiritual: | |  | | | | | | | | | | | | |
| Financial Benefit Advice: | |  | | | | | | | | | | | | |
| End of Life Care Planning: | |  | | | | | | | | | | | | |
| End of Life Care: | |  | | | | | | | | | | | | |
| Wellbeing Service: | |  | | | | | | | | | | | | |
| Respite: | |  | | | | | | | | | | | | |
| **Additional Information** Please give all relevant information to support this referral | | | | | | | | | | | | | | |
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| **GP/Consultant/Key Professionals Contact Details:** | | | | | | | | | | | | | | |
| GP Name:  Practice:  Address:  Postcode:  Contact Number: | | | | | | Other professional name:  Job Title:  Address:  Postcode:  Contact Number: | | | | | | | | |
| Other Agencies Involved: Please tick appropriate box(s) below | | | | | | | | | | | | | | |
| Dietician  Nurse Specialist  Occupational Therapist  Physiotherapist  Nursery/School | | |  | Speech & Language  Social Worker  Carer Support  Independent Care Provision  Mental Health Team | | | | |  | | Navigo  Psychology  Spiritual Lead  Learning Disability Team | | |  |

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| Initial Home Risk Assessment: | |
| How many adults/children live in the home with the patient? | Are there any pets in the home? |
| Are there any noticeable hazards e.g. parking difficulties/street lighting/smokers within the home etc? YES  NO  If yes, please provide details: | |

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| **Referrer Details:** | |
| Name:  Address:  Postcode:  Main Contact Number: | Please state the relationship to the patient or your professional role? |

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| Completed by: | | | | |
| Name |  | Date & Time | Position Held | Main Contact Number |
|  | |  |  |  |