

**Joint Referral Form for Supportive,**

**Palliative and End of Life Care**

|  |  |  |
| --- | --- | --- |
| **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 |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| **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 |
| DieticianNurse SpecialistOccupational TherapistPhysiotherapistNursery/School | **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**  | Speech & LanguageSocial WorkerCarer SupportIndependent Care ProvisionMental Health Team | **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**  | NavigoPsychologySpiritual LeadLearning Disability Team | **[ ]** **[ ]** **[ ]** **[ ]**  |

|  |
| --- |
| 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: |

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

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