**Specialist Palliative Care and Palliative Wellbeing Referral Form** ***please* ✓ key service required** **PAGE 1 of 2**

**Watford General Hospital Inpatients**  **West Herts Specialist West Herts Out Of Hours**

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

Tel: 01923 217930 **All palliative & EOL referrals** Tel: 020 3826 2377

wherts-tr.pallativecare@nhs.net Tel: 0333 234 0868

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

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

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

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

|  |  |
| --- | --- |
| **SURNAME** | **Male  Female  Other** |
| **FIRST NAME Known as** |  |
| **ADDRESS**  **POSTCODE**  **Email** | **PRIMARY DIAGNOSIS**  **DATE of DIAGNOSIS** |
| **HOME Tel**  **MOBILE Tel** | **NHS number**  **DOB** |

|  |  |  |  |
| --- | --- | --- | --- |
| **MAIN CARER:**  **Relationship to patient**  T**el:** | | **NEXT of KIN** (if different):  **Relationship to patient**  **Tel:** | |
| **Who does the patient live with?**  Main Language? Interpreter needed? Yes/No  Religion  Ethnicity | | | ***Mental Health needs Yes/No***  ***Learning disability Yes/No***  ***Please provide additional information with referral*** |
| **GP NAME**  **Is GP aware of referral? Yes/No** | **Tel**  **Email** | | **Surgery Name** |
| **DISTRICT NURSE involved Y / N** | **KNOWN TO** | | **Based at** |
| **Name of other Specialist Service involved** | **Name of staff member** | | **Tel**    **Email** |
| **Funding for care approved : Yes /No If in progress please forward application paperwork**  **Approval for: Fast Track CHC (Nursing Home)  Rapid Personalised Care Service RPCS (Home)  Social care** | | | |
| **Does the patient have capacity to make decisions Yes/No**  **If No, please complete Mental capacity assessment and Best interest documentation**  **Has the patient consented to referral to Specialist Palliative Care Yes/No**  **Does the patient have LPA: Health Yes /No Finance Yes/No Further information:** | | | |
| **Have any advance care planning discussions been offered? Yes/No**  **Have any advance care planning discussions taken place? Yes/No**  **If yes, what outcomes:**  **Is DNACPR completed? Yes/No Is patient on EPaCCS? Yes/No** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS** | | | | |
| Date | History, tests and treatment | | | Consultant and hospital |
|  |  | | |  |
| **MRSA Status C. Diff Status Other infection** | | | **MOBILITY** | |
| **PLEASE SEND COPIES OF ALL RECENT CLINICAL LETTERS, HOLISTIC ASSESSMENT PAPERWORK, MENTAL CAPACITY ASSESSMENT, BEST INTEREST DECISION and DISTRESS THERMOMETER if completed** | | | | |
| **WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?** | | | | |
| **Does the patient have pressure ulcers? Yes/No If Yes, specify grade** | | | | |
| **OACC - AKPS (please indicate percentage) ….... %**  **Phase of Illness – *please* 🗸  Stable  Unstable  Deteriorating  Dying  Unknown**  **Rockwood Frailty Scale Score: …………  Unknown** | | | | |
| **Main Reasons for Referral - *please* ✓** | | **Service requested - *please* ✓ Subject to triage** | | |
| **Care in the last days of life**  **Symptom control ☐**  **Emotional/psychological/spiritual support (patient)**  **Emotional/psychological/spiritual support (family/carer)**  **Social/financial support (patient)**  **Social/financial support (family/carer)**  **Rehabilitation**  **Other** | | **Hospice Admission  Community Palliative Care**  **Can patient attend clinic Yes/No**  **Specialist Palliative Care Outpatient Assessment**   **Day Services /Wellbeing services**  *Grove House* Rennie Grove Hospice Care  *Spring Centre* Hospice of St Francis *Starlight Centre* Peace Hospice | | |
| **The patient is currently ; ( eg Hospital/Home)** | | | | |
| **☐ If in Hospital Name: Hospital Ward: Date of Discharge:** | | | | |
| |  | | --- | | **REFERRER’S NAME JOB TITLE**  **CONTACT NUMBER:**  **Referrer’s signature:** Date: |   **PLEASE ATTACH CLINIC LETTERS, CURRENT MEDICATION AND PATIENT SUMMARY** | | | | |