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| **PROSPECT PALLIATIVE CARE SERVICES PROSPECT HOSPICE - PATIENT REFERRAL FORM** | | | | | | | | | | | |
| **PLEASE FORWARD TO FAX NUMBER: 01793 815803 or EMAIL: spoc.prospect@nhs.net** | | | | | | | | | | | |
| **(please attach Patient Summary/discharge letter/MDT Proforma and any consultant letters relevant to the referral)** | | | | | | | | | | | |
| **Is this referral a new referral or a re-referral:** | | | | |  |  |  |  | **NEW** | | **RE REF** |
| **Has the patient consented to a referral to Prospect Hospice:** | | | | | | |  |  | | **YES** | **NO** |
| **Does the patient have mental capacity to consent to referral to our services:** | | | | | | | | | | **YES** | **NO** |
| **IF YOU HAVE NOT GAINED VALID CONSENT FROM THE PATIENT WE CANNOT ACCEPT THE REFERRAL** | | | | | | | | | | | |
| **Mental Capacity Assessment** | | |  |  |  |  |  |  |  | |  |
| Is there an impairment of, or disturbance in the functioning of the person’s brain/mind? | | | | | | | | | | **YES** | **NO** |
| Is the impairment/disturbance sufficient that the person lacks capacity to make the decision in question? | | | | | | | | | | **YES** | **NO** |
| **If NO to either question assume capacity - If YES proceed to Phase 2** | | | | | | | | | | | |
| ***PHASE 2*** |  |  |  |  |  |  |  |  |  | |  |
| **If patient lacks capacity to consent to referral, has the decision to refer to Prospect Hospice been made under a best interest framework and who was involved in this discussion? (Please send copy of POA if you have one)** | | | | | | | | | | **YES** | **NO** |
| • Can the patient understand the information about the decision to be made? | | | | | | | | | | **YES** | **NO** |
| **Explanation:** | | | | | | | | | | | |
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| • Retain the information to enable them to make a decision? | | | | | | | | | | **YES** | **NO** |
| **Explanation:** | | | | | | | | | | | |
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| • Can the person use or weigh up the information as part of the decision making process | | | | | | | | | | **YES** | **NO** |
| **Explanation:** | | | | | | | | | | | |
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| • Can the person communicate their decision? | | | | | | | | | | **YES** | **NO** |
| **Explanation:** | | | | | | | | | | | |
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| **No to any of the above questions represents a lack of capacity – Mental Capacity Code of Practice 2005** | | | | | | | | | | | |
| **Are key relatives and carers aware of the referral?** | | | | |  |  |  |  | **YES** | | **NO** |
| **Are you expecting the patient to die within the next 6 - 12 months** | | | | | | |  |  | **YES** | | **NO** |

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| **\*If patient is DS1500 eligible please also fax copy to us\*** | | | | | | | | | | | | | | | | | | | | | |
| **Referral Date:** |  | | **Date Referral Received:** | | | |  | | | **Time of Referral:** | | | |  | | **Taken by:** | | |  | |
|  |  | | |  |  | |  | |  | | |  | |  | | |  |  |  | |
| **Referred by:** | **GP** | **D/N** | | | | **Hosp CNS** | | **Hosp Doctor** | | | **Care Home** | | **Relative/ Friend** | | **Self-referral** | | | | | **Other** |

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| ` | **Name of referrer:** |  |  | **Consultant:** | |  | |  | |
|  | **Profession:** |  |  |  |  |  | |  |
|  | **Contact Number:** |  |  |  |  |  |  |  |

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| **PATIENT DETAILS** | |  |  |  |  | **DATE OF BIRTH:** | | |  | | | |
| **Title:** | |  | | |  | **NHS No:** | | | |  | | |
| **Name:** | |  | | |  | **Hospital No:** | | | |  | | |
| **House No./Name:** | |  | | |  | **Prospect No:** | | | |  | | |
| **Address:** | |  | | |  |  |  | |  | |  |  |
| **Town:** | |  | | |  | **NOK – Name:** | | | |  | | |
| **County:** | |  | | | **Relationship to patient:** | | | | |  | | |
| **Postcode:** | |  | | |  | **Contact Details:** | | | |  | | |
| **TELEPHONE** | |  |  |  |  |  |  | |  | | | |
|  | **Home:** |  | | |  |  |  | |  | |  |  |
|  | **Work:** |  | | | **Are they also emergency contact:** | | | **YES** | | | | **NO** |
|  | **Mobile:** |  | | | **Emergency Name, Relationship to patient + Contact Details** | | | | | | | |

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|  | **Lives alone:** | | **YES** | **NO** |  | |  |  |  | |  |  | |  |
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|  | **ETHNICITY** |  | | | | **RELIGION** | | | |  | | |
| **GP DETAILS** | | |  |  |  | |  |  |  | |  |  | |  |
|  | **GP:** | |  | | | |  |  | **CCG** | | | **Swindon** | |  |
|  | **Surgery:** | |  | | | |  |  |  | |  | **Wiltshire** | |  |
|  | **Telephone:** | |  | | | |  |  |  | |  | **Glos** | |  |
|  |  | |  |  |  | |  |  |  | |  | **Other** | |  |
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| **LOCATION OF PATIENT:** | | | Home | | | Hospital | | | | Nursing Home | | | | | Other | |  | | |
|  |  | |  |  |  | |  |  |  | |  | |  | | | |  | |
| **SERVICES INVOLVED:** | | | **Name** | | | | | | **Telephone Number** | | | | | | |  | |  |
| **District Nurse:** | | |  | | | | | |  | | | | | | |  | |  |
| **Social Worker/Care Manager:** | | |  | | | | | |  | | | | | | |  | |  |
| **Care Agency:** | | |  | | | | | |  | | | | | | |  | |  |
| **Physiotherapist:** | | |  | | | | | |  | | | | | | |  | |  |
| **Occupational Therapist:** | | |  | | | | | |  | | | | | | |  | |  |
| **Specialist Nurse:** | | |  | | | | | |  | | | | | | |  | |  |
| **Other:** | | |  | | | | | |  | | | | | | |  | |  |
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| **Allergies:** | | **YES** |  | **NO** |  | |  |  |  | |  | |  | | | |  | |
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| **PRIMARY DIAGNOSIS (the main condition you are referring your patient for):** | | | | | | | | | | | |  | |  | | | |  |
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| **Does the patient understand the diagnosis?** | **YES** |  | **NO** |  |  |  |

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| **ESTIMATED PROGNOSIS:** | | **Days** | | **Weeks** | | | **Months** | | | **Years** | | | **Unknown** |  |
|  |  |  |  | |  |  | |  |  | |  |  | |  |
| **Does the patient understand the prognosis?** | | | | | | **YES** | |  | **NO** | |  |  | |  |
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| **Is there a TEP in place?** | | **YES** | | |  | **NO** | |  | **If yes, please send a copy with referral.** | | | | | |
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| **MAIN REASON FOR REFERRAL:** | |  | | **History/Other Significant disease or information including current medication/treatment: For non-malignant referrals: What have been the recent changes to suggest that this patient is moving towards the end of their life?** | | | | | | | | |
| \* input X into relevant box(s) | |  | |
|  |  |  |  |  | | | | | | | | |
| Pain/symptom control | |  |  |
| Emotional/psychosocial support | |  |  |
| Social/financial | |  |  |
| Assessment for IPU admission | |  |  |
| Carer Support | |  |  |
| Respite Care | |  |  |
| Terminal Care | |  |  |
| Other |  |  |  |
|  |  |  |  |
|  |  |  |  |  | | | | | | | | |
| **COMMUNICATION:** | |  |  | | | | | | | | | |
| Cognitive Function: | |  | | | | | | | | | | |
| Barriers to Communication: | |  | | | | | | | | | | |
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| **SOCIAL SITUATION:** | | | | | | | | | | | | |
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| **RISK ASSESSMENT:** (PLEASE RECORD SUPPORTING DETAILS IN THE BOX BELOW) | | | | | | |  | |  |  | |  |
| **Are there any known Safeguarding issues?:** | | | | | **YES** |  | **NO** |  | |  |  | |

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| Is there any reason known to you or any practising agency why Prospect Hospice should have any concerns visiting the home, or admitting a patient to the In-patient Unit or Day Hospice with regard to:- | | | | | | | | |
| **(A) LONE WORKER:** | **YES** |  | **NO** |  |  |  |  |  |
| **(B) Do we need to visit in 2’s:** | **YES** |  | **NO** |  |  |  |  |  |
| **(C) PHYSICAL OR ENVIRONMENTAL** (e.g. animals/reptiles/birds, radiation or access problems): | | | | | | | | |
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| **URGENCY OF REFERRAL:** | | **Immediate** | |  | contact & review within24 hrs |  | |  | |  |
|  |  |  | **Urgent** |  | contact within 2 working days | |  | |  | | |  |
|  |  |  | **Routine** |  | contact within 3-5 working days | |  | |  | | |  |