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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:** |   |   |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **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** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **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: |   |
|  |  |  |  |  |  |  |  |  |  |  |
| **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 |  |  |  |