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| **PROSPECT HOSPICE REFERRAL FORM DURING COVID-19 PLEASE SEND TO** [**spoc.prospect@nhs.net**](mailto:spoc.prospect@nhs.net)  **(PLEASE ATTACH TO THE EMAIL A GP Patient Summary/discharge letter/MDT Proforma/ any consultant letters relevant to the referral AND \*If patient is DS1500 eligible please send this with the referral** | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Referral Date: | | | Date Referral Received: | | | Time of Referral: | | | | Taken by: | | | | | | | | | GP | D/N | Hosp CNS | Hosp Doctor | | Care Home | Relative/ Friend | | | Self-referral | | | | | Other: | | | | | Name of Referrer: | | | | Profession : | | Consultant : | | | | | | | | | | | | | Contact Number: | | | |  | | | | | | | | | | | | | | |  | | | | | | |  | |  | | | |  | | | | 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 | | |  | | | Are key relatives and carers aware of this referral: | | | | | | | | Yes | | |  | No | | |  | | | Has the patient consented to information sharing with their relatives about his/her clinical condition | | | | | | | | Yes | | |  | No | | |  | | |  | | | | | Are you expecting the patient to die in the in the next 6-12 months: | | | | | | | | Yes | | |  | No | | |  | | | Is the patient imminently dying: | | | | | | | | Yes | | |  | No | | |  | | | What is the patient’s COVID-19 status: | | | | | | | | Confirmed | | |  | Suspected | | |  | | Not Suspected | |  | | Does the patient have mental capacity to consent to referral to our services: | | | | | | | | Yes | | |  | No | | |  | | | Has the decision to refer been made under a best interest framework | | | | | | | | Yes | | |  | No | | |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PATIENT DETAILS** |  | **NEXT OF KIN DETAILS** | | | | Title: |  | Title: | | | | Name: |  | Name: | | | | DATE OF BIRTH: |  | Relationship to Patient: | | | | NHS No: |  | House No./Name: | | | | Hospital No: |  | Address: | | | | Prospect No: |  | Town: | | | | House No./Name: |  | County: | | | | Address: |  | Postcode: | | | | Town: |  | TELEPHONE: | | | | County: |  | Home: | | | | Postcode: |  | Work: | | | | TELEPHONE |  | Mobile: | | | | Home: |  | Are they also emergency contact:  *(If No please complete below)* | YES 🞏 | NO 🞏 | | Work: |  | **Emergency Name, Relationship to patient + Contact Details:** | | | | Mobile: |  | | **GP Surgery and Registered GP:** |  | |  | |  | | GP Telephone: |  | | CCG: Swindon󠄄🞏 Wiltshire 🞏 Glos 🞏 Other🞏 |  | | | | | | | | | | | | | |
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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **SERVICES INVOLVED:** | **Name** | **Telephone Number** |  |  | | **District Nurse:** |  |  |  |  | | **Social Worker/Care Manager:** |  |  |  |  | | **Care Agency:** |  |  |  |  | | **Physiotherapist:** |  |  |  |  | | **Occupational Therapist:** |  |  |  |  | | **Specialist Nurse:** |  |  |  |  | | **Other:** |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **PRIMARY DIAGNOSIS (the main condition you are referring your patient for):** | | | | | | | | **CLINICAL ISSUES** |  | ✓ |  |  |  | | Pain | Yes |  | No |  | | Agitation | Yes |  | No |  | | Nausea | Yes |  | No |  | | Vomiting | Yes |  | No |  | | Dyspnoea | Yes |  | No |  | | Swallowing Independently | Yes |  | No |  | | Urinary Incontinence | Yes |  | No |  | | Urinary catheter | Yes |  | No |  | | Faecal Incontinence | Yes |  | No |  | | Constipation | Yes |  | No |  | | Expectorating Independently | Yes |  | No |  | | Other : | | | | | |  | Days |  |  |  | |  | Weeks |  |  |  | | Estimated Prognosis | Months |  |  |  | |  | Years |  |  |  | |  | Unknown |  |  |  | | Does the patient understand the prognosis? | Yes |  | No |  | | Is there a TEP in place? *If yes, please send a copy with referral.* | Yes |  | No |  |   **MAIN REASON FOR REFERRAL: \* input X into relevant box(s)**   |  |  |  |  | | --- | --- | --- | --- | | **Pain/symptom control** |  | **Carer Support** |  | | **Emotional/psychosocial support** |  | **Terminal Care** |  | | **Social/financial** |  | **Other** |  | |  |  |  |  |  |  | | --- | | **Social Situation:** |  |  |  |  | | --- | --- | --- | | **COMMUNICATION:** | | | | **Can the patient communicate independently:** | **Yes** | **No** | |  |  | | *If no: please specify:* | | **Other Barriers or Requirements to facilitate communication:** | | |   **RISK ASSESSMENT:**  **Are there any Risks or known Safeguarding issues? Yes 🞏 No 🞏** | | | | | | | |  |  | |  | |  | |

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| **(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): | | | | | | |
| **Any other information:** | | | | | | |

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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 | |  | |  | | |  |