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| **FORM A PROSPECT HOSPICE REFERRAL FORM DURING COVID-19 PLEASE SEND TO** **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**  |
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| Referral Date:  | Date Referral Received | Time of Referral:  | Taken by:  |
| GP | D/N | Hosp  | 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 |   |

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| **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:  |  | Are they also emergency contact:*(If No please complete below)*  | Is there anyone in the household other than the patient who is in the SHIELDED GROUP? YES  NO IF YES WHO? |
| Mobile:  |  |
| **GP Surgery and Registered GP:**  |  |
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|  |
| 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  | 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 |  |
| Patients Preferred Place to Die Known? **If yes, please state where:-**   | Yes  |  | No |  |

**MAIN REASON FOR REFERRAL: \* input X into relevant box(s)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pain/symptom control** |  | **Terminal Care** |  |
| **Emotional/psychosocial support** |  | **Advance Care Planning** |  |
| **Social/financial** |  | **Medical Out Patient Review** |  |
| **Carer Support** |  | **Inpatient Unit Admission** |  |
|  |  |  |  |

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| **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 🞏** |  |  |  |  |
| **(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):  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **URGENCY OF REFERRAL:**  | **Immediate** |  | Initial Telephone consultation within 24 hrs |  |
|  |  |  | **Urgent**  |  | Initial Telephone consultation within 2-3 working days |
|  |  |  | **Routine** |  | Initial Telephone consultation within 5-10 working days |
|  |
| **Please make sure your patient and their family know that Prospect IPU is a short stay unit** | FEB 2021 |