REFERRAL FORM

All referrals must be accompanied by recent relevant correspondence.

Criteria for referral

The patient has a diagnosis of advanced life limiting illness and:

- symptom control or other complex problems which are escalating or are unable to be managed by the current clinical team. These symptoms may be physical, psychological, spiritual, social, or family/ carer orientated issues.
- complex social needs resulting from their illness or whose families show exceptional emotional distress.
- has capacity and has consented to referral or lacks capacity for this decision but it is agreed to be in their best interests.

Patient details:

NHS number: ..... Patient consents to specialist palliative care involvement ☐ Yes ☐ Unable ☐ No

Surname: ..... ☐ Male ☐ Female ☐ Unknown ☐ Unspecified Date of birth: .....

First name: ..... Marital status: .....

Address: .....

Postcode: ..... Ethnicity: ..... Religion: ..... Telephone: .....

Do they live alone? ☐ Yes ☐ No (add details if complex) .....

Referrer's name: ..... Job title: .....

Contact number: ..... Bleep number: ..... Date: .....

Surgery or hospital: .....

Next of kin/carer:

Name: ..... Relationship to patient: .....

Telephone: ..... Mobile: .....

Second patient contact:

Name: ..... Relationship to patient: .....

Telephone: ..... Mobile: .....

District nurse: Involved: ☐ Yes ☐ No

Name: ..... Based at: .....

Telephone: ..... Fax: .....

Care package: ☐ Yes ☐ No If yes how is it funded? ☐ Private ☐ CCG

General practioner:

Name: ..... Name of practice: .....

Telephone: ..... Fax: .....

Email: .....

Communication:

Language if not English: ..... Communication in English: ☐ Good ☐ Fair ☐ Poor

Would an interpreter be helpful? ☐ Yes ☐ No

Other barriers to communication eg hearing loss or confusion

Patient name: ..... NHS number: .....

In-patient details (if appropriate)

Hospital: ..... Ward: ..... Hospital number: .....

Telephone: ..... Direct ward ext: ..... Date of discarge (if known): .....

Consultant 1: ..... Consultant 2: .....

Hospital palliative care team involved: ☐Yes ☐No Key team CNS/contact .....

Main diagnosis(es): .....

Other significant medical and mental health problems: .....

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Brief history of diagnosis(es) and key treatments:

Outcome Assessment and Complexity Collaborative (OACC): .....

Karnofsky score: ..... **Estimated prognosis:** ☐Days ☐Weeks ☐Months

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Hospice service(s) required:

☐Home assesment and support ☐Out-Patient Clinic ☐Day services ☐Physiotherapist
☐Occupational Therapist ☐Pharmacy ☐Patient and Family Support Worker
☐Clinical Nurse Specialist ☐Hospice at Home
☐Inpatient admission; reason(s): ☐Symptom control ☐Terminal care ☐Other

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Advanced care planning:

ACP specific document in use: ☐Yes ☐No Preferred place of care: .....

Preferred place of death if different: ..... Current DNACPR form in place: ☐Yes ☐No

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Reasons for referral:

☐Uncontrolled symptoms ☐Carer support
☐Other reason eg lymphoedema please detail: .....

Please detail below essential information needed by service to support care (or attach relevant documents):

1. Details of symptom control advice/treatment already in place.
2. All recent annotations/clinic letters/investigation results.
3. List of current medication and allergies or copy of patient summary care record.
4. Any additional information which may be useful.

Urgency of referral: ☐2 working days ☐5 working days *If two day referral must be followed by a telephone call from referrer for immediate advice.

Allergies/ sensitivities: .....

Insight:

Has patient been told diagnosis? ☐Yes ☐No Is patient aware of prognosis? ☐Yes ☐No
Is the carer aware of patient's prognosis? ☐Yes ☐No Is the carer aware of patient's referral? ☐Yes ☐No
Does patient discuss the illness freely? ☐Yes ☐No Please provide details in essential information section if any "No" responses

Does the patient have transport available to them to be seen at the hospice? ☐Yes ☐No

Please attach recent annotations with this referral when sending it to JTHCIC.referral@nhs.net

Please complete the referral form in full to ensure the referee receives an appropriate and timely response.

The information you are supplying in this referral form is personal and sensitive (as defined by the Data Protection Act 1998) and should be sent to us securely.
Referral forms will be emailed to the John Taylor Hospice secure email site. If you choose to email, we cannot guarantee the security of information until it is in our possession and will not take responsibility for such information until we receive it. If you do not have a secure email, you must ensure that you make alternative arrangements.

Advice Notes for Adult Specialist Palliative Care (SPC) Referral

Referrals can be made by any health or social care professional. Patient self-referral is also accepted, supported by a health or social care professional.

1. Criteria for referral:
N.B. If unsure of the appropriateness of a referral, please discuss with the SPC team prior to referral.

Specialist palliative care services are for patients with complex problems which can arise from multiple domains of need: physical or psychological symptoms, or spiritual/emotional distress.

Patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress may also be referred.

Prior to referral patients with capacity must consent. Referral must be judged to be in the best interests of patients who do not have capacity.

The patient has a diagnosis of advanced life limiting illness and has complex needs. These needs may be driven by be physical, psychological, spiritual or family and carer orientated issues which are escalating and are felt to be unmanageable within the resources or palliative care experience of their current clinical team in their present setting (eg home, hospital, care home).

2. Urgent referrals must be made by phone call to the appropriate specialist team, followed by a fax of the referral form.

3. All referral forms must be sent securely to the appropriate specialist team via secure email or fax.

4.Referral forms MUST be accompanied by relevant clinic letters and discharge summaries.

5. Standards for response:
a. Contact made by specialist team within 2 working days. Referrer MUST contact SPC team by phone for advice when making a 2 day referral.
b. Contact made by specialist team within 5 working days.

6. Appropriate response from the specialist team can be at 4 levels of intervention:
i. Telephone support/advice from specialist palliative care service to other care professionals and attendance at MDT. This level of intervention does not require a referral form to the service.
ii. One-off specialist assessment visit, with or without attendance by managing clinical team.
iii. Short term contact with specialist palliative care service to stabilise situation in partnership with usual clinical team/key worker.
iv. Ongoing contact with specialist palliative care service in partnership with usual clinical team key worker.

7. Following the first contact, whether made by phone or face to face, if further contact or visits are declined then the referring team will be contacted.