**Patient Referral Form for Specialist Palliative Care** **Private and Confidential**

****

St John’s Hospice, Slyne Road, Lancaster, LA2 6ST

Telephone: 01524 382538

**Please complete ALL questions and email to** [**MBCCG.SJH.Referrals@nhs.net**](mailto:MBCCG.SJH.Referrals@nhs.net?subject=SJH%20Patient%20Referral)**.**

Charity Number

1157030

**Incomplete forms will cause delay in this referral being processed.**

|  |  |  |
| --- | --- | --- |
| **Service(s) requested (Please click boxes):**  Inpatient Admission  North Lancashire Clinical Nurse Specialists  Hospice at Home – GSF amber/red only  Day and night Respite – GSF amber/red only  Day Services (including Fatigue, Anxiety and Breathlessness (FAB) group) | | |
| **Consent:**  Is the patient aware of and consented to referral  Y  N  If No give details: | | **Referred by**:  Name:  Job Title:  Organisation:  Email address:  Tele No:  Referral date: |
| **Patient Details:**  Name: Gender:  Address:  Date of Birth:  NHS No:  Tele No: Home:  Mobile: | | **GP:**  Current location of patient:  Contact No if not at home:  Does the patient live alone?  Y  N  Does the patient have a care package  Y  N  Does the patient have Continuing Healthcare funding  Y  N |
| **First Contact:**  Relationship to patient:  Address:  Tele No: Aware of referral?  Y  N | | **Main Carer** (if different):  Relationship to patient:  Address:  Tele No: Aware of referral?  Y  N |
| **Life shortening Diagnosis**: Date of Diagnosis:  **Relevant Medical History:**  **Allergies:** | | |
| **Reasons for referral** (please include details of symptoms, current/previous treatment tried, psychological needs etc) | | |
| **Advance Care Planning:**  What is patient’s current GSF status?  Red (days)  Amber (weeks)  Green (months)  PPC?  Home  Hospice  Nursing Home/Care home  Other  PPD?  Home  Hospice  Nursing Home/Care home  Other  ‘Just in Case’ drugs?  Y  N  DNACPR completed?  Y  N | | |
| **For inpatient admission:**  Oxygen requirement  Y  N  If Yes – Flow rate: \_\_\_\_\_\_\_\_\_  Infections requiring specific precautions:  Y  N  More information if Yes:  Does the patient smoke?  Y  N  Is the patient under 146cm/4’9” tall?  Y  N  Does the patient weigh over 150kg/25st?  Y  N  Does the patient have any pressure sores/wounds?  Y  N  Any specific equipment requirements (including bariatric): | **For community referrals (H@H & CNS):**  Smokers in the home?  Y  N  Known infections?  Y  N  More info if Yes:  Any family concerns?  Y  N  More info if yes:  Any known risks at home?  Y  N  More info if yes:  Keysafe?  Y  N | |
| **For Day Services referrals:**  Do they have transport to and from a group?  Y  N  Can the patient participate in group work (no significant sensory or cognitive impairment)?  Y  N | |
| **Any additional information to help prioritise this referral:** | | |

**Upon completion, save a copy of this referral form and email it to**

[**MBCCG.SJH.Referrals@nhs.net**](mailto:MBCCG.SJH.Referrals@nhs.net?subject=SJH%20Patient%20Referral)