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

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

Telephone: 01524 382538

**Please complete ALL questions and email to** **MBCCG.SJH.Referrals@nhs.net****.**

Charity Number

1157030

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

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| **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 [ ]  NIf 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 [ ]  NDoes the patient have a care package [ ]  Y [ ]  NDoes 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 [ ]  OtherPPD? [ ]  Home [ ]  Hospice [ ]  Nursing Home/Care home [ ]  Other‘Just in Case’ drugs? [ ]  Y [ ]  NDNACPR completed? [ ]  Y [ ]  N |
| **For inpatient admission:**Oxygen requirement [ ]  Y [ ]  NIf Yes – Flow rate: \_\_\_\_\_\_\_\_\_Infections requiring specific precautions: [ ]  Y [ ]  NMore information if Yes: Does the patient smoke? [ ]  Y [ ]  NIs the patient under 146cm/4’9” tall? [ ]  Y [ ]  NDoes the patient weigh over 150kg/25st? [ ]  Y [ ]  NDoes the patient have any pressure sores/wounds?[ ]  Y [ ]  NAny specific equipment requirements (including bariatric):  | **For community referrals (H@H & CNS):**Smokers in the home? [ ]  Y [ ]  NKnown infections? [ ]  Y [ ]  NMore info if Yes:Any family concerns? [ ]  Y [ ]  NMore info if yes:Any known risks at home? [ ]  Y [ ]  NMore info if yes:Keysafe? [ ]  Y [ ]  N |
| **For Day Services referrals:**Do they have transport to and from a group? [ ]  Y [ ]  NCan 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**