**REFERRAL FORM FROM HEALTH CARE PROFESSIONAL FOR PALLIATIVE CARE SERVICES provided by St Elizabeth Hospice in SUFFOLK.**

**Please complete as much information as possible as incomplete forms may delay processing of the referral.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **565 Foxhall Road, Ipswich, IP3 8LX**  **Telephone 01473 707006/7**  **Email** [**chu-ftr.stelizabethsecs@nhs.net**](mailto:chu-ftr.stelizabethsecs@nhs.net)  **OneCall Advice line 0800 5670111** | | | | | | | | | | |  |
| **SERVICE REQUIRED**: | | | **If this referral is for emergency contact today, please complete form as well as calling 0800 5670111.** | | | | | | | | Date of referral:    Name of referrer: |
| (**What would you want us to consider**- we will use this information together with our assessment of the patient and carers needs to decide which is the best service to offer.) | | |
| **PATIENT DETAILS:** | | | | | | | | | | | |
| **Who are you referring? The Patient?** | | | Yes No | **Is patient aware of referral?** | | | | | Yes No | | |
| Why not? | | | | |  | | |
| **And/or family member(s)** | | | Yes No | **Is family aware of referral?** | | | | | Yes No | | |
| Why not? | | | | |  | | |
| **Name:** |  | | **Known as:** |  | | | | | **Gender:** | |  |
| **DOB:** |  | **NHS No:** |  | | | | **Hospital No:** | | | |  |
| **Address (incl. post code):** | |  | | | | | | | | | |
| **Home Phone:** | |  | | **Mobile Phone:** | |  | | | | | |
| **Is the Patient:** | | **At Home** | **Care Home/Other (give details):** | | | |  | | | | |
| **In Hospital** | | **Which Hospital/Ward?** |  | | | **Proposed Discharge Date:** | | | | |  |
| **Diagnosis (incl. date of diagnosis):** | | |  | | | | | | | | |
| **Other Medical Conditions:** | |  | | | | | | | | | |
| **Marital Status:** | |  | **Ethnic Origin:** |  | | **Religion:** | |  | | | |
| **REASON FOR REFERRAL (What unmet needs have triggered this referral now?)** | | | | | | | | | | | |
|  | | | | | | | | | |  | |
| **Bereavement** | | | | | | | | | |  | |
| **Complex End of Life Issues** | | | | | | | | | |  | |
| **Complex Psychosocial / Family** | | | | | | | | | |  | |
| **Complex Symptom Control** | | | | | | | | | |  | |
| **Rehabilitation (Palliative)** | | | | | | | | | |  | |
| **Spiritual Distress** | | | | | | | | | |  | |
| **Wellbeing** | | | | | | | | | |  | |
| **What is it you are hoping we can do?** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| In order for us to be able to view information shared by e.g. GP / District Nurse with St Elizabeth Hospice we will require explicit consent from the patient: | | | | | | | | | | | |
| **Has the patient consented to the sharing of their SystmOne electronic patient record with St Elizabeth Hospice?** | | | | Yes No | | | | | | | |
| **DETAILS OF MAIN PROBLEMS:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **ADDITIONAL INFORMATION (including psychosocial, recent bereavement(s)/losses):** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **CURRENT MEDICATION/ANY KNOWN ALLERGIES:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **CURRENT/PREVIOUS TREATMENT:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **What are your plans for follow up?** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **OTHER SPECIFIC PATIENT NEEDS:** | | | | | | | | | | | |
| **First language:** | |  | | **English Speaker?** | | | | |  | | |
| **Communication/Language issues:** | | |  | | | | | | | | |
| MRSA Status  Pos  Neg | | C Difficile Status  Pos  Neg | | | **Other infection risk?** | | | | | |  |
| **Details of how to get there:** | |  | | | | | | | | | |
| **Details of care package** (incl. any in place, Continuing Care)**:** | | | |  | | | | | | | |
| **Mobility/Disability Issues:** | |  | | | | | | | | | |
| **Equipment Needs** (incl. any in place): | | |  | | | | | | | | |
| **Oxygen Support Y/N** Please specify: | | |  | **Bariatric Needs Y/N** please specify: | | | | | | |  |
| **Lone Worker Issues Y/N** please specify: | | |  | | | | | | | | |
| **Are there any hazards in the home? Y/N** please specify: | | | |  | | | | | | | |
| **PROFESSIONALS INVOLVED** | | | | **CARERS** | | | | | **Next of Kin:** | | **First Contact?** |
| GP: | |  | | Name: | | | | |  | | |
| Practice: | |  | | Address: | | | | |  | | |
| On GSF Register: | |  | |
| Consultant: | |  | | Contact No: | | | | |  | | |
| Others: | |  | | **Significant Other:** | | | | | **First Contact?** | | |
| Relationship: | | | | |  | | |
| Name: | | | | |  | | |
| Address: | | | | |  | | |
|  | | | | |
|  | |  | | Contact No: | | | | |  | | |
|  | | | | | | | | | | | |
| **REFERRER DETAILS** | |  | | Designation: | | | | |  | | |
| Name: | |  | | Telephone: | | | | |  | | |
| Date of referral: | |  | | Email: | | | | |  | | |