**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****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: |       |