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| **St Teresa’s Hospice Multidisciplinary Referral Form** | | | | | | | | | | | | | | | | | |
| **Referral Date: Referral Time:** | | | | | | | | | | | **Office use only**  Referral taken by: | | | | | | |
| **Patient Name (inc title):**  **Preferred name:** | | | | | | | | | | | **Referrer Details:**  **Name:** | | | | **Profession:** | | |
| **DOB:** | | **Age:** | | | | **Sex:  M  F** | | | | | **Address:** | | | |  | | |
| **NHS No:** | | | | | | | | | | | **Post code:** | | | | **Tel:** | | |
| **Address:**  **Post code: Tel:**  **Living Alone?  Yes  No**  **Temporary address:**  **Ethnic Origin: Religion:**  **Language:**  **NOK and/or Main Carer** (name & relationship):  **Address:**  **Tel: Mobile:** | | | | | | | | | | | **Hospital:**  **Ward number:** | | | |  | | |
| **GP Surgery:** | | | |  | | |
| **Professional Support:**  **Name:**  **1.**  **2.** | | | **Organisation:** | | | **Designation:** |
| **Diagnosis: Date:**  **Prognosis:**  Days  Weeks  Months | | | | | | |
| **Which service is needed?** | | | | | | | | | | | | | | | | | |
| In Patient Unit  Nurse Consultant  Lymphoedema  Family Support Team (Social Work/counselling)  *Macs use only* | | | Day Hospice  Heart Failure Clinic  Respiratory Clinic  Neurology Clinic  Acupuncture  Massage | | | | | | | Rapid Response **(Darlington)**  Hospice at Home  Home Care **(CHC only)**  Volunteer Visitor | | | | | Satellite Day HospiceNY  Respiratory Group NY  Blood Transfusion  Other | | |
| **Referral Priority?** | | | Urgent | | | | | | | *Routine* | | | | |  | | |
| **Current symptoms/Problems/Assessed Needs:** | | | | | | | | | | | | | | | | | |
| Pain | Nausea/vomiting | | | | | | Breathlessness | | | | | Bedbound | | | | Psychological | |
| Anxiety | Agitation | | | | | | Confusion | | | | | Housebound | | | | Social | |
| Falls/Risk of falls | Delirium | | | | | | Constipation | | | | | Lymphoedema | | | | End of life care | |
| Mobility | Needs assistance | | | | | | Fully mobile | | | | | Communicate needs | | | |  | |
| Other (please specify) |  | | | | | |  | | | | |  | | | |  | |
| **Reason for referral: PLEASE SELECT ONE REASON ONLY** | | | | | | | | | | | | | | | **FST Referrals Only** | | |
| Symptom Control | | | | Blood Transfusion | | | |  | | | | | | | Bereavement Support | | |
| End of Life Care | | | | Lymphoedema | | | |  | | | | | | | Support for Carers | | |
| Crisis Management | | | | Emotional/Psychological/Carer Support | | | | | | | | | | | Advice & Support | | |
| **Please tick if this referral is preventing a hospital admission:** | | | | | | | | | Prevent Hospital Admission | | | | | | | | |
| **Please expand (i.e. specific reason for referral):** | | | | | | | | | | | | | | | | | |
| **DNACPR in place:** Yes No | | | | | **ACP:** Yes No | | | | | | | | **CHC funded:** Yes No | | | | |
| **Equipment in the home:** | | | | | | | | | | | | | | | | | |
| **Has patient agreed to the referral?** Yes No  **Has the patient agreed to share out** (*information from our unit*) **their Electronic Record?** Yes No Not asked  **Has the patient agreed to share in** (*information from other units*) **their Electronic Record?** Yes No Not asked | | | | | | | | | | | | | | | | | |
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| Addressograph: |



**Additional Information:**

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| --- | --- | --- |
| **Current Medical History** | | |
| **Treatment to date**  Chemotherapy: Yes  No  Radiotherapy: Yes  No  Surgery: Yes  No  Date of surgery if within 12 months: | Is the patient currently taking any oral/S/C  Oncology treatments that they would be taking/ administering whilst an inpatient: Yes  No  If yes please give details: | |
| **Significant Past Medical History:**  Heart Disease  Respiratory disease  On oxygen therapy  Diabetes: Type 1 Type 2  Renal disease  liver disease  Psychotic illness  Personality changes  Aggression  Dementia  Substance abuse  Epilepsy/Prone to seizures  Other:  **Infectious diseases:** CDiff  MRSA | | |
| **OACC Assessment Scores:**  **Phase of Illness: …………………………. Karnofsky: …………………………. Barthel: ………………………….** | | |
| **Allergies:** No  Yes (please state): | | |
| **PPC:** Home  Hospice  Hospital  Care Home  Other (please state):  **PPD:** Home  Hospice  Hospital  Care Home  Other (please state): | | |
| **Does the patient have capacity:** Yes  No  If **No** please supply **‘Best Interest/DOLs’** documentation | | |
| **Wounds/skin integrity:** | | |
| **Nutrition:** | | |
| **Breathing:** | | |
| **Communication:** | | |
| **Other information and main reason for referral:** | | |
| **Next of Kin**  **Name:**  **Address:**  **Post code:** | | **Relationship to Patient:**  **Tel no (home):**  **Tel no (work/mobile):** |