

Specialist Palliative Care (SPC) Community and SPC Inpatient Unit Referral Form

(1/3)

Specialist Palliative Care Community Teams & Inpatient Units across South & West London

Greenwich & Bexley Community Hospice Bostall Hill, Abbey Wood SE2 0GB Home care: Tel: 020 83205837 Fax: 020 83205839 Admissions: Tel: 020 83122244 Fax: 020 83124344	Lewisham Macmillan Community Team: Lewisham High Street SE13 6LH Tel: 020 8333 3017 Fax: 020 8333 3270	St Christopher's Hospice Lawrie Park Rd, London SE26 6DZ Home care: Tel: 020 8776 5656 Fax: 020 87765798 Admissions: Tel: 020 87684582 Fax: 02086595051 St Christopher's Bromley Tel: 01689 825755 Fax: 01689 892999
Guy's & St Thomas' Community Team: Guy's Hospital, Great Maze Pond SE1 9RT Tel: 020 71884754 Fax: 020 71884748	Meadow House Hospice Southall UB1 3HW Tel: 020 89675179 Fax 020 89675756	St John's Hospice Grove End Road, St John's Wood NW8 9NH Tel:020 78064040 Fax: 020 78064041
Harlington Hospice St Peter's Way, Harlington UB3 5AB Tel: 020 87590453 Fax: 020 87590600	Michael Sobell House Northwood, Middlesex HA6 2RN Tel:01923 844531 Fax: 01923 844565	St Luke's Hospice Kenton Road, Harrow HA3 0YG Tel: 020 83828001 Fax: 020 83828080
Harrow Community Team Kenton Road, Harrow HA3 0YG Tel: 020 83828084 Fax: 020 83828085	Pembroke Palliative Care Centre Exmoor Street, W10 6DZ Tel: 020 8962 4410 Inpatient Fax: 020 89624422 Community Services Fax: 020 89624413	St Raphael's Hospice London Road, North Cheam SM3 9DX Tel: 020 80997777 Fax: 020 8099 1724
Hillingdon Community Team Pield Heath Road, Uxbridge UB8 3NN Tel:01895 279412 Fax: 01895 279452	Princess Alice Hospice West End Lane, Esher KT10 8NA Tel: 01372 461804 Fax: 01372 470937	Trinity Hospice Clapham Common SW4 0RN Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065 Fax: 020 7787 1067

For further information and advice on these services, please visit the Help the Hospices service directory at:
<http://www.helpthehospices.org.uk/about-hospice-care/find-a-hospice/uk-hospice-and-palliative-care-services/>
 and enter the postcode provided above.

Every LCA hospital has a Specialist Palliative Care team;
 if your patient is a *hospital inpatient*, please contact the team, via the relevant hospital switchboard.

FAX MESSAGE

From:	To:
Fax No:	Date:
No. of pages (incl cover sheet):	

Additional information

Confidentiality: The content of this fax and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above.

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM – including recent clinic letters, blood tests and most recent imaging

NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT

PATIENT NAME **NHS No:**.....

Essential Patient Details		
Surname	Male/Female Age:	Patient consent to palliative care involvement? Yes <input type="checkbox"/> No <input type="checkbox"/>
First Name	DoB	Is GP aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address		
Postcode	Marital Status	Ethnicity
Tel	Mob	
NHS number		Hospital No.

Primary diagnosis(es)

Communication	Other barriers to communication / registered disabilities:
Fluent in English? Yes <input type="checkbox"/> No <input type="checkbox"/> (If 'no' proceed with remaining questions)	
First Language, if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Next of Kin/Patient Representatives	District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	General Practitioner
Name	Name	Name
Address	Based at	Address
	Telephone	
Telephone	Fax	
Relationship to patient		Postcode
Main Carer (if different from above)	Social Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Telephone
Name	Name	
Telephone	Based at	Fax/email
Relationship to patient	Tel Fax	CCG:
	Continuing care assessment completed: Yes/No	
	Continuing care funding agreed: Yes/No	
Reason for Referral	Service requested	The patient is currently
Pain/symptom control..... <input type="checkbox"/>	Home assessment and support..... <input type="checkbox"/>	At Home..... <input type="checkbox"/>
Emotional/psychological support..... <input type="checkbox"/>	Hospital assessment <input type="checkbox"/>	In Hospital (see over)..... <input type="checkbox"/>
Social/financial..... <input type="checkbox"/>	Day Care..... <input type="checkbox"/>	Other e.g. Nursing Home..... <input type="checkbox"/>
Assessment for hospice admission..... <input type="checkbox"/>	Outpatient service..... <input type="checkbox"/>	Please specify.....
Carer support..... <input type="checkbox"/>	Admission (circle)..... <input type="checkbox"/>	
Other reason (please give details below)..... <input type="checkbox"/>	Respite / symptom control / terminal care	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
.....	Hospice at Home..... <input type="checkbox"/>	

Any access issues (e.g. key safe):	
MRSA Status Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/>	Any other communicable infection:
Special device in situ? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give details (e.g. trache / PEG / ICD / NIPPV):.....	
Referrer's Name: (please print)	Contact number: Bleep no:
Hospital/Surgery:	This information required on both pages if faxing

IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/>
IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

In-Patient details		Patient Name:	
Hospital		NHS No:	
Ward	Direct Ward Ext.	Telephone	
Key worker		Date of discharge (if known)	
Consultant		Is Palliative Care team involved? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Brief History of diagnosis(es) and Key treatments		
Date	Progression of disease and investigations/treatment	Consultant and hospital

Current palliative care problems	
1.	4.
2.	5.
3.	6.
Patient Mobility:	Bariatric Nursing required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Any other comments/information (including preferences expressed about care or other psychosocial or spiritual issues)

Referrer's expectation of current treatment (please circle) symptom control / life prolonging / curative
Prognosis: In your opinion, is the patient
Stable? Yes <input type="checkbox"/> No <input type="checkbox"/> Unstable? Yes <input type="checkbox"/> No <input type="checkbox"/> Deteriorating? Yes <input type="checkbox"/> No <input type="checkbox"/> Dying? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is death anticipated within: Months <input type="checkbox"/> Weeks <input type="checkbox"/> Days <input type="checkbox"/>

Patient on Coordinate My Care? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If not please give reason.....
On the GSF register? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> DNACPR in place? Yes <input type="checkbox"/> No <input type="checkbox"/>

Past Medical and Psychiatric History	Current Medication	
		Known Drug Sensitivities/Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Details:

Insight: Has patient been told diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the carer aware of patient's diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does patient discuss the illness freely Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature:	Name: (please print)
Job title:	Contact number: Bleep no:
Surgery or Hospital:	Date: