Keech Hospice Care Adult Service Referral Form

Patients must be aware of their referral

Criteria: Adult patient who has a diagnosis of a progressive life limiting disease and are in the palliative stage of their illness. They will be symptomatic with difficult or complex psychological, social or spiritual issues.
Please complete this form in BLOCK CAPITALS and return by email to: mycarecoordinationteam@nhs.net

Mr/Mrs/Ms/Dr	Male/Female	Patient's First Name:	Patient's Surname:
NHS Number:	Hospital Number:	Date of Birth:	Marital Status:
Address:			Postcode:
Tel. No.:	Occupation:	Religion:	1st Language (or means of communication if not spoken)
Email Address:		Consultant Details:	

Ethnic Origin:

- ☐ White British
- ☐ White Irish
- ☐ White Other
- ☐ Mixed White/Black Caribbean
- ☐ Mixed White/Black African
- ☐ Mixed White/Asian
- ☐ Other Mixed
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Other Asian
- ☐ Black Caribbean
- ☐ Black African
- ☐ Other Black

Next of Kin and/or Carer

Next of Kin Name:	Relationship to Patient:	Main Carer Name:	Relationship to Patient:
Next of Kin Address:		Main Carer Address:	
Next of Kin Home Tel. No.:	Next of Kin Mobile Tel. No.:	Main Carer Home Tel. No.:	Main Carer Mobile Tel. No.:

Professional Details

GP's Name:	GP Address:
GP Surgery: GP Surgery Tel. No.:	
District Nurse:	District Nurse Tel. No.:
MacMillan/Specialist Nurse Name:	MacMillan/Specialist Nurse Tel. No.:
Social Worker Name:	Social Worker Tel. No.:
Key Worker Name:	Key Worker Tel. No.:

Referral Reason (please tick one)

☐ Stable	☐ Unstable	☐ Deteriorating	☐ Dying

Patients current functional status (Karnofsky Performance Status): %

100% Normal, no complaints, no evidence of disease **90%** Able to carry on normal activity, minor signs or symptoms of disease **80%** Normal activity with effort, some signs or symptoms of disease **70%** Cares for self, but unable to carry on normal activity or to do active work **60%** Able to care for most needs, but requires occasional assistance	**50%** Considerable assistance and frequent medical care required **40%** In bed more than 50% of the time **30%** Almost completely bedfast **20%** Totally bedfast and requiring extensive nursing care by professionals and/or family **10%** Comatose or barely arousable, unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly.

Describe the patients main concerns (please continue on a separate sheet if necessary):

Have discussed with patient and they will benefit from: (please tick one box)

- ☐ Inpatient Care
- ☐ Ascitic Drainage
- ☐ Keech Palliative Care Centre (Outpatient Service)
- ☐ Complementary Therapy (only)
- ☐ Emotional Support
- ☐ Palliative Care Social Worker
- ☐ Hospice at Home (Volunteers)
- ☐ Supportive Care Team (Pre/post bereavement support, emotional support, creative therapies, family support, complimentary therapy, spiritual support)
- ☐ Independence and Wellbeing Service (OT and Physio)

My Care Co-Ordination Team Caseload (Verbal consent gained) ☐ Yes ☐ No

Diagnosis and treatment

Diagnosis (including date of diagnosis): (please attached or fax relevant clinical letters)

Current Treatment: (please attach if necessary)	Current Medication: (please attach if necessary)
Past Medical History: (please attach if necessary)	Allergy/Sensitivity/Dietary Requirements:

Current Symptoms:

- ☐ Pain
- ☐ Breathlessness
- ☐ Reduced physical independence
- ☐ Weight loss/reduced appetite
- ☐ Sleep problems
- ☐ Urinary tract symptoms
- ☐ Bowel symptoms
- ☐ Nausea and vomiting
- ☐ Confusion
- ☐ Ascites
- ☐ Low mood/depression/anxiety
- ☐ Eating disorder
- ☐ Poor body image
- ☐ Spiritual needs
- ☐ Social isolation (Hospice at home referrals only)
- ☐ Social care advice
- ☐ Carer under stress
- ☐ Speech/hearing, sensory impairment
- ☐ Mental health issues
- ☐ Hallucinations
- ☐ Psychosocial/emotional needs

Advanced Care Plan Completed: ☐ Yes ☐ No	Preferred Place of Care:
Has SystmOne been shared: ☐ Yes ☐ No	Has patient consented to share: ☐ Yes ☐ No
DNACPR in place: ☐ Yes ☐ No	Is transport required: ☐ Yes ☐ No If yes: ☐ By car ☐ Wheelchair Accessible Vehicle ☐ Ambulance Stretcher

IF THIS FORM IS NOT FULLY COMPLETED THIS WILL DELAY THE REFERRAL TO OUR SERVICES

Name of referee:	Role:
Contact details:	Date: