**Request for Inpatient Hospice Care Form**  

**Please Complete in Full to Avoid Delay**

*Any request for a transfer of a patient to Pilgrims Hospice’s inpatient ward will not be considered without the following information to ensure that we are able to safely care for them.*

*Please note when completing this form that each stand-alone hospice has only 3 nursing staff on out of office hours, there is no on-site medical cover during this time*

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| **PATIENT DETAILS** | | | | | | | | |  | **GP/REFERRER DETAILS** | |
| Surname: |  | | | | | First Name: |  | |  | Name: |  |
| D.O.B.: |  | | | | | Gender: |  | |  | Code: |  |
| Age: |  | | | | | NHS No.: |  | |  | Address: |  |
| Address: |  | | | | | | | |  |
|  |
| Post code: |  |
| Home Tel.: |  | | | | Mobile: | |  | |  | Post code: |
| Other Tel: |  | | | | Other Tel Name: | |  | |  | Tel. No.: |  |
| Interpreter required? | Yes |  | No |  | First Language: | |  | |  | E-mail: |  |
| Current Place of Care | | Home | | | Care Home | | Hospital | Other |  |  | |
| If Hospital, Site & Ward: | |  | | | Ward Direct Line: | |  | |  |  | |

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| **PATIENT ENGAGEMENT AND AVAILABILITY** | | | | | | |
| **I confirm the following:**  I have discussed the referral to the hospice for support with end of life care and the patient has consented and understands that Pilgrims may need to access the relevant information on their GP record. The patient is aware that they will be contacted by a member of staff from the hospice. If the patient lacks capacity the referral must be made in Best Interests of patient in conformance with Mental Capacity Act. | | | | | | |
| Name: |  | | Role: |  | Date: |  |
| Best Interest Decision Maker Name (if relevant): | |  | | | | |

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| **Which Sites Would the Patient Accept?**  ***Please Note that Bariatric Beds Are Only Available at Canterbury*** | | | | | |
| Pilgrims Hospice Ashford |  | Pilgrims Hospice Canterbury |  | Pilgrims Hospice Thanet |  |

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| **CLINICAL SUMMARY OF PATIENT’S CONDITION (Additional Information from EMIS Record At End of Form)** |
| *Please include current main diagnosis, treatments, the patient’s and family’s understanding, etc.:* |
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| **CEILING OF TREATMENT DISCUSSED AND AGREED WITH PATIENT AND FAMILY *– Please Tick*** | | | |
|  | **1** | **Intensive** | Transfer to hospital if appropriate. Intubation, ventilation etc. should be considered |
|  | **2** | **Hospital** | Transfer to hospital for treatment if appropriate, DNACPR in place |
|  | **3** | **Home** | Treatment, medication and comfort measures within the community with support from GP. Admission to hospital would be avoided unless comfort measures fail |
|  | **4** | **Comfort** | For comfort measures only. Admission to hospital would be avoided unless comfort measures fail [e.g. Fracture neck of femur] |
| **KARNOFSKY PERFORMANCE SCALE *– Please Tick*** | | | |
|  | **100 – 80** | | Able to carry on normal activity and to work; no special care needed |
|  | **70 – 50** | | Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed |
|  | **40 – 0** | | Unable to care for self; requires equivalent for institutional or hospital care; disease may be progressing rapidly. |

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| **EOL INFORMATION** | | | | | |
| DNACPR Form Completed: | Yes |  | No |  |  |
| Preferred Place of Care: |  | | | | |
| Preferred Place of Death: |  | | | | |

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| In your opinion, can this patient be safely looked after in a normal bed, in a unit with a maximum of 3 nursing staff and no overnight medical cover? | | | | |
| Yes |  | No |  | If the answer is no, please call the ward and speak to the nurses |

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| **ADDITIONAL PATIENT INFORMATION – *Please Tick Any That Apply and Provide Any Relevant Additional Information*** | | | | | | | | | | |
| **Mental Capacity** | Is patient able to make simple day to day choices and decisions? | | | | Yes | |  | No |  |  |
| Is patient able to make complex decisions about treatment & care? | | | | Yes | |  | No |  |  |
| Is there an LPA for Health & Welfare? | | | | Yes | |  | No |  |  |
| Is there an LPA for Property & Financial Affairs? | | | | Yes | |  | No |  |  |
| **DOLS** | | Yes |  | Additional Info: | |  | | | | |
| **Safeguarding Issues** | | Yes |  | Additional Info: | |  | | | | |
| **Falls Risk/Mobility Issues** | | Yes |  | Additional Info: | |  | | | | |
| **Infection Issues** | | Yes |  | Additional Info: | |  | | | | |
| **Delerium/confusion** | | Yes |  | Additional Info: | |  | | | | |
| **Syringe Driver or Medicine Patch** | | Yes |  | Additional Info: | |  | | | | |
| **Pressure Ulcers** | | Yes |  | Additional Info: | |  | | | | |
| **Oxygen therapy** | | Yes |  | Additional Info: | |  | | | | |
| **Bariatric/ Needs more than two to deliver care or move** | | Yes |  | Additional Info: | |  | | | | |
| **Complex family dynamics** | | Yes |  | Additional Info: | |  | | | | |
| **Has the Patient got a Continuing Healthcare Funding Agreement** | | Yes |  | Additional Info: | |  | | | | |
| **Communication Difficulties** | | Yes |  | Additional Info: | |  | | | | |
| **Any Other Considerations** | | Yes |  | Additional Info: | |  | | | | |

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| **Aware of visitors policy** | Yes |  | No |  |

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| **PATIENT CLINICAL INFORMATION FROM MERGED GP ELECTRONIC RECORDS** | |
| Allergies: |  |
| Active Problems: |  |
| Investigations: |  |
| Significant past history: |  |
| Current medication: |  |
| Repeat medication: |  |

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| **PERSON FILLING IN FORM** | | | |
| Name: |  | Hospital: |  |
| Office Number: |  | Email Address: |  |
| Mobile Number: |  |