

**Pilgrims Hospice Referral Form**

**Completed Forms to Be Emailed to: PH.PilgrimsHospices@nhs.net**

|  |  |  |
| --- | --- | --- |
| **PATIENT DETAILS** |  | **GP 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 |  |  |

|  |
| --- |
| **URGENCY OF THE REFERRAL. To be contacted (tick which one applies)** |
|  | Within 24 hours (please call 01233 504133 to discuss) |  | Within 48-72 hours |  | Within 7 days |

|  |
| --- |
| **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): |  |

|  |
| --- |
| **CLINICAL SUMMARY OF PATIENT’S CONDITION (Additional Information from EMIS Record At End of Form)**  |
| *Please include current main diagnosis, treatments, etc:**What is important for Pilgrims to know, to best meet the needs of the patient and their family?* |
|

|  |
| --- |
|  |

 |
| Is the patient at risk of being in the last year of life? | Yes |  | No |  | If no please ring to discuss: 01233 504133 |

|  |
| --- |
| **SERVICE(S) REQUIRED (Please Tick Those that Apply)** |
| **Pilgrims Therapy Centre** | Breathlessness Management |  | Living with Anxiety |  | Energise, Exercise |  |
| Living with Fatigue |  | Planning for the Future |  |  |  |
| Wellbeing Cafe |  | Sit Down, Get Fit |  |  |  |
| **Community/Outpatient Care** |  | **Rapid Response – Hospice@Home HCAs to support dying at home, thought to be in the last 72hrs of life** |  |
| **Inpatient Admission** |  |  |

|  |
| --- |
| **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] |

|  |
| --- |
| **ADDITIONAL PATIENT 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 |  |  |
| **Safeguarding Issues** | Yes |  | No |  | Additional Info: |  |
| **Infection Issues** | Yes |  | No |  | Additional Info: |  |
| **Communication Difficulties** | Yes |  | No |  | Additional Info: |  |
| **Any Other Considerations** | Yes |  | No |  | Additional Info: |  |

|  |
| --- |
| **NEXT OF KIN DETAILS** |
| Relationship to Patient: |  | Name: |  |
| Home Number: |  | Address: |  |
| Mobile Number: |  |
| **MAIN CARER DETAILS (if Different to Next of Kin)** |
| Relationship to Patient: |  | Name: |  |
| Home Number: |  | Address: |  |
| Mobile Number: |  |  |

|  |
| --- |
| **PATIENT CLINICAL INFORMATION FROM MERGED GP ELECTRONIC RECORDS** |
| Allergies: |  |
| Active Problems: |  |
| Investigations: |  |
| Significant past history: |  |
| Current medication: |  |
| Repeat medication: |  |
| **PERSON FILLING IN FORM**  |
| Name: |  | Hospital: |  |
| Office Number: |  | Email Address: |  |
| Mobile Number: |  |