Katharine House Hospice, Weston Road, Stafford, ST16 3SB

Please email completed form to **khhospice.referrals@nhs.net**, if you wish to talk to a member of staff regarding this referral please call **01785 270832**

**If you wish to make a referral to Hospice at Home please ring 07966502551, 0800-2000 Monday – Sunday. Please do not send this referral form as all referrals are taken by phone**

Please indicate which service is required

 PCNS Team [ ]  In-Patient Unit [ ]  Day Hospice [ ]  Lymphoedema [ ]

 Reason for Referral [ ]  Assessment [ ]  End of Life Care [ ]  Pain/symptom Control [ ]

 Carer Support/Respite [ ]  Emotional/psychological support [ ]  Outpatient Clinic [ ]

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| --- | --- | --- | --- |
| Name Of Referrer | Referrer Contact Details | Date | Please tick if urgent 1-3 days |
|  |  |  |  |
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**Patient Details**

|  |  |
| --- | --- |
| First Name  | Surname  |
| Male [ ]  Female [ ]   | Marital Status |
| DOB | Age  | NHS No |
| Address | Telephone No |
| Mobile |
| Ethnicity |
| Religion |
| Post Code | Occupation |

DOES PATIENT LIVE ALONE YES [ ]  NO [ ]

PATIENT’S CURRENT LOCATION: HOME [ ]  HOSPITAL [ ]  WARD [ ]

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| --- | --- | --- | --- |
| Name of Main Carer |  | Address |  |
| Relationship |  | Telephone |  |
| Next of Kin(if different) |  | Address |  |
| Relationship |  | Telephone |  |

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| --- | --- |
| GP Practice | GP |
| Telephone NO |
| **Patient’s Name**  | **NHS No**  | **Date of Birth** |

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| Diagnosis (including metastases) |
| Date | Investigations/treatments | Consultant and hospital |
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| Troublesome symptoms at present and recent management |
|  | 4.  |
|  | 5.  |
|  | 6.  |

Patient’s Phase (if known) AKPS Score

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| --- | --- |
| Medication/Allergies | Relevant medical history |
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| **Does this patient have signs or symptoms of / or previous history of (circle as appropriate)** |
| MRSA [ ]   | Clostridium difficile [ ]   |
| Other infection (please specify) |
| **Does this patient have any pressure sores (circle as appropriate)** |
| Yes [ ]  No [ ]   | If yes please advise grade  |

Estimated prognosis (Tick) Days [ ]  Weeks [ ]  Months [ ]

**Is the patient aware of is the carer aware of**

1. This referral Yes [ ]  No [ ]  This referral Yes [ ]  No [ ]
2. Their diagnosis Yes [ ]  No [ ]  The patient’s diagnosis Yes [ ]  No [ ]
3. Their prognosis Yes [ ]  No [ ]  The patient’s prognosis Yes [ ]  No [ ]

**DNAR discussed**

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| --- | --- | --- | --- | --- |
| With Patient  | Yes [ ]  | No [ ]  | If Yes date  | By Whom  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| With Family  | Yes [ ]  | No [ ]  | If Yes date  | By Whom  |

|  |
| --- |
| Any other comments/information**Please ensure patients are aware information will be held on computer according to Data Protection Act** |

Referrer’s Signature…………………………………………………………………. Name (please print) ……………………………………………….

Job Title……………………………………………………………………………………. Contact number……………………… Bleep No

Surgery or Hospital…………………………………………………………………. Date ………………………………………………………………………..

**Patients Name Date of Birth NHS No**

**For Internal Use Only**

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| Referral Not Proceeding Date |
| **Reason** Inappropriate – does not meet referral criteria – state whyOut of areaNot discharged from hospital/died before dischargePatient / family requestOther |
| Communication  |
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| Communication |
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