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

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

**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

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

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

|  |  |  |
| --- | --- | --- |
| Diagnosis (including metastases) | | |
| Date | Investigations/treatments | Consultant and hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Troublesome symptoms at present and recent management | |
|  | 4. |
|  | 5. |
|  | 6. |

Patient’s Phase (if known) AKPS Score

|  |  |
| --- | --- |
| Medication/Allergies | Relevant medical history |
|  |  |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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**

|  |
| --- |
| Referral Not Proceeding  Date |
| **Reason**  Inappropriate – does not meet referral criteria – state why  Out of area  Not discharged from hospital/died before discharge  Patient / family request  Other |
| Communication |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| Communication |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |