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

A referral form can be downloaded from the Hospice website [www.khhospice.org.uk](http://www.khhospice.org.uk).

Please email completed form to [khhospice.referrals@nhs.net](mailto:khhospice.referrals@nhs.net)

To talk to a member of staff regarding the referral please call the Patient Pathway team on 01785 270832. 0900-1700 Mon-Fri

If you wish to make a referral to **Hospice at Home** please ring 07966 502551, 0800-2000 Mon-Sun

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details:** | | | | | | | | | | | | | | | | | | | |
| First Name | | | | | | | | | | Surname | | | | | | | | | |
| Male/Female | | | | | | | | | | Marital Status | | | | | | | | | |
| DOB | | | | | | Age | | | | NHS No | | | | | | | | | |
| Address | | | | | | | | | | Telephone No | | | | | | | | | |
| Mobile | | | | | | | | | |
| Religion | | | | | | | | | |
| Ethnicity | | | | | | | | | |
| Occupation | | | | | | | | | |
| GP Practice | | | | | | | | | | GP | | | | | | | | | |
| Telephone No | | | | | | | | | |
| **Please indicate which service is required:** | | | | | | | | | | | | | | | | | | | |
| PCNS Team |  | | In Patient Unit | | | | | |  | | Wellbeing/Counselling Centre | | | |  | | Lymphoedema | |  |
| **Reason for referral:** | | | | | | | | | | | | | | | | | | | |
| Assessment | | | | |  | | Pain / Symptom Control | | | | | | | | |  | | End of Life Care |  |
| Carer Support / Respite | | | | |  | | Emotional/Psychological Support | | | | | | | | |  | | Outpatient Clinic |  |
| **Please Specify if referral is:** | | | | | | | | | | | | | | | | | | | |
| Urgent (1 Working day) | |  | | Priority (3 Working Days) | | | | | | | |  | Non Urgent (5-7 Working Days) | | | | | |  |
| **Patient’s Location:** | | | | | | | | | | | | | | | | | | | |
| Home | |  | | Hospital (state): | | | | | | | | | | Ward: | | | | | |
| **Does the patient live alone?** | | Yes | | |  | | No |  | | |  | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any issues with mental capacity?** | Yes |  | No |  |
| **Has a mental capacity assessment been completed?** | Yes |  | No |  |

**FAILURE TO COMPLETE ALL THE SECTIONS OF THIS FORM MAY RESULT IN DELAY CONTACTING THE PATIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative / Carer Details:** | | | |
| Name of Main Carer |  | Address |  |
| Relationship to Patient |  | Telephone |  |
| Next of Kin  (if different) |  | Address |  |
| Relationship to patient |  | Telephone |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis:** | | | |  | | | | | | | | | | | | | | | | | | |
| **Background:** | | | | | | | | | | | | | | | | | | | | | | |
| **Medication:** | | | | | | | | | | | | | | **Allergies:** | | | | | | | | |
| **Anticipatory Medications in place?** | | | | | | | | | Yes | | | | | | | | | |  | No |  | |
| **Relevant medical history:** | | | | | | | | | | | | | | | | | | | | | | |
| **BMI (Required for Lymphodema)** | | | | | | | | | | | | |  | | | | | | | | | |
| **Please attach any recent scans and blood results including EGFR.**  **Please attach current annotations.** | | | | | | | | | | | | | | | | | | | | | | |
| **Troublesome symptoms at present and recent management** | | | | | | | | | | | | | | | | | | | | | | |
| Pain | | | | | | | | | | |  | | | Gastro-intestinal issues | | | | | | |  | |
| Breathlessness | | | | | | | | | | |  | | | Agitation | | | | | | |  | |
| Anxiety | | | | | | | | | | |  | | | Patient in last few days of life | | | | | | |  | |
| **Summary and steps already taken to address symptoms / issues:** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Does this patient have signs or symptoms of / or previous history of** | | | | | | | | | | | | | | | | | | | | | | |
| Infections (i.e. MRSA/Covid) | | | | | | | | | | | | | | | | | | | | | | |
| **Does this patient have any pressure sores:** | | | | | | | | | | | | | | | | Yes |  | No |  | Unknown | |  |
| If Yes, Grade: | |  | | | Has a Safeguarding been raised? | | | | | | | | | | | | Yes |  | No | | |  |
| **Prognosis:** | Days | |  | | | Weeks | |  | | | Months | | | |  | | | | | | | |
| **RESPECT in place:** | | | | | Yes | |  | | | No | |  | | |
| **DNAR decision made** | | | | | Yes | |  | | | No | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the patient aware of:** | | | | | | **Is the carer aware of** | | | | |
| This Referral | Yes |  | No | |  | This Referral | Yes |  | No |  |
| Their Diagnosis | Yes |  | No | |  | Their Diagnosis | Yes |  | No |  |
| Their Prognosis | Yes |  | No | |  | Their Prognosis | Yes |  | No |  |
| Known to District Nurse:  If no please consider referral to District Nursing Service in addition to this referral | | | | | | | Yes |  | No |  |
| District Nurse Team Name | | | |  | | | | | | |
| Based At | | | |  | | | | | | |
| Telephone number | | | |  | | | | | | |
| **If the answer is no to any of the above please expand:** | | | |  | | | | | | |
| **Any other comments / Other information:** | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer Details:** | | | | | |
| Print Name |  | Signature |  | | |
| Job Title |  | Contact No: |  | Ext/Bleep |  |
| Surgery / Hospital |  | Date |  | | |

**Please email completed form to** [**khhospice.referrals@nhs.net**](mailto:khhospice.referrals@nhs.net)

**FAILURE TO COMPLETE ALL THE SECTIONS OF THIS FORM MAY RESULT IN DELAY CONTACTING THE PATIENT**