**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

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**

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| **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 |  |

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