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

**In order to have the best chance of this referral being reviewed, accepted and hospice services offered to the patient quickly please complete as much of this referral form as possible to give us all the information we need to prioritise our referrals and allocate care based on the patient needs**

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

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| **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 | | | | | | Out-Patient | | | | 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 which): | | | | | | | | | | | Ward: | | | | |
| **Does the patient live alone?** | Yes | | |  | | No |  | | |  | | | | | | | | |

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| **Diagnosis:** | | |  | | | | | | | | | | | | | | | | | | | |
| **History of diagnosis** | | | |  | | | | | | | | | | | | | | | | | | |
| **Relevant past medical history** | | | |  | | | | | | | | | | | | | | | | | | |
| **Troublesome symptoms at present** | | | | | | | | | | | | | | | | | | | | | | |
| Pain | | | | | | | | |  | | Gastro-intestinal issues | | | | | | | | | |  | |
| Breathlessness | | | | | | | | |  | | Agitation | | | | | | | | | |  | |
| Anxiety | | | | | | | | |  | | Patient in last few days of life | | | | | | | | | |  | |
| Other (please explain) | | | | | | | | |  | | | | | | | | | | | | | |
| **Summary and steps already taken to address symptoms / issues:** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Prognosis** | | | | | **Days** | | | | | **Weeks** | | | | | | | **Months** | | | | | |
| **Respect in Place** | | | | | **Yes** | | | | | **No** | | | | | | | | | | | | |
| **DNAR in place** | | | | | **Yes** | | | | | **No** | | | | | | | | | | | | |
| **Phase of Illness** | | | | **Stable** | | | | **Unstable** | | | | | **Deteriorating** | | | | | | **Dying** | | | |
| **AKPS** | | | | **100** | | | | **90** | | | | | **80** | | | | | | **70** | | | |
|  | | | | **60** | | | | **50** | | | | | **40** | | | | | | **30** | | | |
|  | | | | **20** | | | | **10** | | | | | **0** | | | | | |  | | | |
| **Medications** | | | | |  | | | | | **Drug Allergies** | | | | | | | **Food Allergies/Dietary Requirements** | | | | | |
| **Anticipatory Medications in Place?** | | | | | | | **Yes** | | | | | | | | **No** | | | | | | | |
| **BMI (rough guess)** | | | | | **Low** | | | | | **Normal** | | | | | | | **High** | | | | | |
| **Mobility** | | **Independent** | | | | | | **Mobility Aids/Carer support** | | | | | **Wheelchair** | | | | | | **Bedbound** | | | |
| **Does this patient have signs or symptoms of / or previous history of** | | | | | | | | | | | | | | | | | | | | | | |
| Infections (i.e. MRSA/Covid/C Diff/ESBL) | | | | | | | | | | | | | | | | | | | | | | |
| **Does this patient have any pressure sores:** | | | | | | | | | | | | Yes | |  | | No | |  | | Unknown | |  |
| If Yes, Grade: |  | | | | | Has a Safeguarding been raised? | | | | | | | | Yes | |  | | No | | | |  |

**If this patient has NOT been under the care of University Hospital of North Midlands, please can you attach any recent scans, blood results and clinic letters as we cannot access these online and they are very useful for us in making our decisions about admission and for the ongoing care for this patient**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any issues with mental capacity?** | Yes |  | No |  |
| **Has a mental capacity assessment been completed?** | Yes |  | No |  |
| **Is there any funding in place currently for care?** | Yes |  | No |  |
| **If Yes, this funding is** | FTF | CHC | Self-funded | Other |
| **Is there a package of care in place currently?** | Yes |  | No |  |
| **If YES, this package of care is** | OD | BD | TDS | QDS |
| **How many carers is this for?** | One |  | Two |  |

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

**Katharine House Hospice Inpatient Unit is a SHORT STAY UNIT. If the patient has had their immediate palliative care needs fully met by the hospice it may be necessary to discharge them for onwards care either into their own home (with a suitable care package if required) or into a long term care facility such as a nursing home.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |
| That KHH may discharge them onwards if their palliative needs are met | Yes |  | No | |  | That KHH may discharge them onwards if their palliative needs are met | Yes |  | No |  |
| **Has the patient consented to this referral** | | | | | | | Yes |  | No |  |
| **If the answer is no to any of the above please expand:** | | | | | | |  | | | |
| **Is the patient already known to KHH services** | | | | | | | Yes |  | No |  |
| **Which service?** | | | | | | | IPU | PCNS | Wellbeing | H@H |
| Counselling | Complementary Therapy | | |
| Lymphoedema | | | |
| 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 | | | |  | | | | | | |
|  | | | | | | | | | | |
| **Any other comments / Other information:** | | | | | | | | | | |
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| --- | --- | --- | --- | --- | --- |
| **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**