Lakelands Hospice @ Home Referral Form

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Essential Patient Details

Surname: **Age:** **DOB:**	**Date of Referral: Time of Referral**
First Name: **Male/Female**	**Has Patient consented to H@H Care** Yes ☐ No ☐
Address: **Post Code:**	**Is GP aware of referral?** Yes ☐ No ☐ **Is patient on Palliative Care Register?** Yes ☐ No ☐
Tel: **Mobile Tel:** **Work Tel:**	**Marital Status:** **Does the patient live alone? No Yes** **Ethnicity:**
NHS number: **Hospital No:**	

Communication Needs?	**DNACPR** Yes No Unknown **Special Patient Note (SPN 111):** Yes ☐ No ☐ Unknown ☐
First Language if not English:	**Any Safeguarding Issues?** ☐
Is interpreter required? Yes ☐ No ☐	

Next of Kin/Patient Representatives **Name:** **Relationship to patient:** **Tel:**		**Address:**
Main Carer (if different from above)	**Name:**	**Tel:**
GP	**SURGERY**	**DISTRICT NURSE**
Macmillan Nurse Yes ☐ No☐ **Tel:**	**Name:** **Fax:**	
Social Services Yes ☐ No ☐ **Tel:**	**Name:** **Fax/email:**	**Based at:** **CHC assessment completed: Yes** ☐ No ☐
Other Professionals: Yes ☐ No ☐	**Name:** **Fax/email:**	**Based at:**

Primary diagnosis	**Date of diagnosis:**	
Past Medical History	**GSF Coding:**	

Insight

Has the patient been told diagnosis**?** **Yes** ☐ No ☐ Is the carer aware of the diagnosis? **Yes** ☐ No ☐

Does the patient discuss the illness freely? **Yes** ☐ No ☐

IF URGENT, PLEASE PHONE FOR IMMEDIATE ADVICE Tel: 01536 747755

Please Fax Completed Form - Fax No: 01536 747788

H@H Care Referral Form

PATIENT NAME: ……

Brief History of Diagnosis and Key Treatments		
Date	Progression of disease and investigations/treatments	Consultant and hospital

Referrer's expectation of care provision *(please circle)* Nightly/ Part of Night/ Certain Nights	
Estimated prognosis *(please circle)* days / weeks	
MRSA Status	**C.Diff Status**

Current problems:
Any other comments/information/ identified risks (including psychosocial or spiritual issues)

Reason for Referral	**Service requested**	**The patient is currently**
Pain/symptom control ☐	Home assessment and support ☐	At Home ☐
Emotion/psychological support ☐	Symptom control/ terminal care ☐	In Hospital (see below) ☐
Carer support ☐		Other ☐
Other reason: please specify		
	Patient Mobility:	

	Current Medication	**Known drug Sensitivities/Allergies:**

In-Patient details – where applicable	
Hospital:	**Tel:**
Ward:	**Date of discharge (if known):**
Consultant:	**Is Palliative Care team involved?** Yes ☐ No ☐
Please ensure patients are aware information will be held on computer in according to the Data Protection Act	
Name of Referrer:	**How Referred:**
Job Title:	**Contact number:** **Bleep no:**
	Date:

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