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| **Referrals to be made electronically via SystmOne or email to appropriate address (see below)****For Hospice referrals please encrypt the message to protect patient data****All urgent referrals should be made by phone** |
| **1. Palliative Care Team** | **2. Saint Michael’s Hospice** |
| Hospital |[ ]  Inpatient unit (GPs & SPCT only) |[ ]
| Community |[ ]  The Wellbeing Network |[ ]
| **Tel: 01423 553464****Electronic referrals accepted via SystmOne or email the specialist palliative care team :** **hdft.palliativecareteam@nhs.net** | Palliative Lymphoedema Clinic (GPs & SPCT only) |[ ]
|  | MND Clinical Nurse Specialist |[ ]
|  | **Electronic referrals accepted via SystmOne****For further information please email:** **hospice-services@saintmichaelshospice.org****To discuss referrals please phone:****01423 879687 (option 3)** |

PALLIATIVE CARE REFERRAL FORM

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| Patient Name: |  | NHS no: |  |
| Prefers to be called: |  | Hospital no: |  |
| Address: | Date of birth: |
| Telephone: |
| Mobile no: |
| Key code: | Lives alone: Yes / No |
| Does the patient have communication issues? If yes, what are they? |  Yes/No |
| Current location of patient:HomeHDFTOther HospitalCare Home | Ward \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Location \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Name \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | Date of admission \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  |
| NOK/contact name: | GP: |
| Relationship: | Surgery: |
| Telephone number: Is this person next of kin? Yes/No Main carer? Yes/No  | Tel: |
|  | **Nursing/other care teams involved:** |
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|  **Diagnosis and treatment history:** **Main concerns/reason for referral**DNACPR in place ? Yes No  | **Saint Michael’s Hospice referrals ONLY:**Detail any supportive interventions e.g. PEG feeding, NIV, oxygen (NB if on oxygen specify L/min):If patient smokes are they aware that they cannot smoke within the Hospice building? YES / NO / N/ALevel of mobility (e.g. aids used):Access to patient’s home (e.g. steps, flat, multi-level etc): |
| Has patient consented to referral? Yes/No |  |
| Name of person making referral:Job title:Contact number: Date:  |  |

February 2023