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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**](mailto: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**](mailto: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:  Home  HDFT  Other Hospital  Care 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:** | |
|  | | | |  | |
| **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/A  Level 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