EAST CHESHIRE HOSPICE @HOME
REFERRAL FORM **Please return to Ecccg.echospiceathome@nhs.net**

For office use only
Date/Time referral received .....
EMIS Number .....
Referral received by .....Designation.....
Time Actioned / Contact made with Referrer.....
Time of Contact with Patient/Family .....

Surname:	Male: ☐	Female: ☐
First Name:	NHS No.	Marital Status:
DOB:	Religion:	Ethnic Group:
Diagnosis:		

Address: Contact No. Current Location: Does the patient live alone: Yes ☐ No ☐	Next of Kin: Relationship: Address Contact No.
<u>Referrer</u> Name: Address: Tel No. Designation: GP ☐ Consultant ☐ Specialist Nurse ☐ District Nurse ☐ Other ☐ (specify)_____	Macmillan/CNS: Base: Tel No.
District Named Nurse: Base: Tel No. Mobile:	GP: Practice: Tel No.

Reason for Referral: (more than one choice acceptable)

Last days / weeks of Life □ Rapid Discharge □ Awaiting Hospice Admission □

Crisis support / Symptom Management □ Emergency Night Sits (limited availability) □

Care Home Support □ Psychological support in last days/weeks of life □

Family support in last days/weeks of life □ On Hold for future care □

Is the patient aware of the referral: Yes □ No □

Is the family/carer aware of referral: Yes □ No □

Referral Priority: RED high/urgent need □ **AMBER** rapidly changing condition □

GREEN Routine, may require support soon – make contact □

Treatment: Please specify commencement and end dates.	
Surgery	
Chemotherapy	
Radiotherapy	
Hormone Therapy	

Relevant Past Medical History:

	Yes	**No**
Has patient consented to referral?		
Is there a blue book/ Anticipatory Meds?		
Has patient consented to information sharing?		
Is patients PPD home?		
Is patient on the GSF?		
Is the patient aware of the diagnosis and prognosis?		
Has the DNACPR been completed?		
Is there community documentation within the home or on EMIS to support care delivery i.e. care plans?		
Is CHC funding agreed?		
Has the GP agreed to Nurse Verification if required?		

Does the patient have any problems with:	**Yes**	**No**	**Details**
Pressure areas			
Pain			
Wounds			
Hygiene			
Mobility/equipment available in the home			
Breathing			
Eating/Drinking			
Medicine Management			
Communication			
Emotional State			
Allergies (please provide full details)			
Anxiety			

Confusion			
Constipation			
Fatigue			
Nausea/Vomiting			

Medication route:				
Oral	Patches	Injections	Syringe driver	Peg

Home Environment			
Accommodation	House ☐ Bungalow ☐ Flat ☐ Warden Controlled ☐ Other ☐		
Detail any problems with access	e.g. parking, key safe details		
Safety Factors	Are there any smokers in the home? Yes ☐ No ☐	Are there any pets in the home? Yes ☐ No ☐	

Details of facilities for staff within the home:	**Yes**	**No**
Toilet		
Heating		
Telephone Access		
Is Wi-Fi available		
Is appropriate seating available		
Are parking / tea / coffee making facilities available		

For H@H Office use only

Additional Information

Fax number for completed referrals: 01625 665697