East Cheshire NHS
NHS Trust

East Cheshire Specialist Palliative Care Referral Form

East Cheshire Hospice
Where people come to live

MACMILLAN. CANCER SUPPORT

1. Patient Details

Title: ________ Surname: ____________________

Forename(s): ________________________________

D.O.B: ______________ Age: _____ M/F: _________

NHS Number: _________________________________

Home Address: _______________________________

Postcode: ________________________________

Home Phone: ________________________________

Mobile Phone:

Lives Alone: _____ Ethnicity: _________________

Religion: __________________

Current Location of patient (include ward if inpatient):

____

2. NOK / Carers Details

Name: ______________________________________

Relationship to Patient: _________________

Address: __________________

Postcode: _________________

Home Phone: _________________

Mobile Phone: _________________

3. Community Health Care Professional Details

GP Name: ___________________________________

GP Practice: _________________________________

GP Phone: ___________________________________

GP aware of Referral: __________________________

District Nurse Team: __________________________

DN Tel No: __________________________

Social Worker: __________________________

SW Tel No: __________________________

Palliative Care Nurse Specialist: _________________

Tel No: __________________________

Other Professionals Involved:

____
____
____
____

4. Hospital Details

Hospital (1): _____________________________________

Consultant (1): ___________________________________

Hospital (2): _____________________________________

Consultant (2): ___________________________________

Clinical Nurse Specialist: ___________________________

Location: ____

5. Service Required (please select as required)

Macmillan Specialist Palliative Care Team

Please Email Ecn-tr.palliativecareteam@nhs.net

or Fax to 01625 661378

Inpatient Hospital Review: _______

Community Review: ___________

Palliative Medicine Consultant Outpatient Clinic

East Cheshire Hospice

Email eccg.echospiceipu@nhs.net

or Fax to 01625 665697

Inpatient Admission

Is this referral for: Action Now

Symptom Management: ____________________

Optimisation/Rehabilitation: ____________________

End of Life Care: ____________________________

Sunflower Centre and Hospice Therapies

Email: eccg.echospicesfc@nhs.net

or Fax to: 01625 666995

Wellbeing assessment: _____________

Living Well: _____________

Breathlessness programme: ______

Lymphoedema assessment: ______

Art Psychotherapy: ______

Complementary Therapy: ______

Physio outpatient assessment: ______

(for Community physio/OT, please refer separately to Community Rehab team, fax no. 01625 661856 or email: ecn-tr.communitytherapieseast@nhs.net)

Separate referral forms for Blood transfusions, Dementia and MND Wellbeing can be found on the hospice website www.eastcheshirehospice.org.uk under 'Professionals'

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Name of patient: ________________________ **DOB:** ______________________

6. Clinical Information about the patient

Primary diagnosis: __________________________________ Date: ________________________

Sites of Metastases & dates: ____

Treatments received and dates: ____

Significant Past Medical History: ____

Allergies: ____

Infection Risk: ____

Any other relevant information: ____

Patient's understanding of illness: ____

NOK understanding of illness:

Resuscitation discussions and outcome:

uDNR-CPR form completed and with patient: _______

Internal cardiac defibrillator (ICD)/ pacemaker insitu: ___

Patient Preferred Place of Care (PPC): _______ Preferred Place of Death (PPD): _____

Continuing Health Care (CHC) Funding Approved: ______

Are the patient and their NOK aware of this referral? Patient: ___________ NOK: __________

Has the Patient given consent for health and social care staff involved in their care and treatment to view their health records: ___________

Current Situation and reason for referral to Specialist Palliative Care:

____

Phase of Illness: ____

Please Indicate on Karnofsky Performance Scale the Current Status of the Patient: ______________________

Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor sign of symptoms of disease	90
Normal activity with effort; some signs or symptoms of disease	80
Cares for self; unable to carry on normal activity or to do active work	70
Able to care for most needs; but requires occasional assistance	60
Considerable assistance and frequent medical care required	50
In bed, more than 50% of the time	40
Almost completely bedfast	30
Totally bedfast and requiring extensive nursing care by professionals and/or family	20
Comatose or barely rousable	10

Referrers Name: _____________________________________

Designation: ______________________________ Contact Number: ______________________ Date: _________________

Macmillan Specialist Palliative Care Team (9am-5pm Monday-Friday) Tel 01625 663177, Fax 01625 661378

Bleep via MDGH Switchboard for Urgent Advice 9am-5pm Monday-Friday 1004 (9602 for Lung Cancer Patients)

East Cheshire Hospice 24 hr Advice line 01625 666999