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| **Eastern Cheshire End of Life Care – Referral Form** | |
| **Patient Details**  **Name:**  **Address**:  **Postcode:**  **Telephone:**  **Current location:**  **Date of Birth:**  **Gender:**  **Religion:**  **Ethnic Group:**  **Does the patient live alone?** Yes / No  ***Please inform the hospice at home team of any key safe info by phone or NHS email.***  **Diagnosis/Medical Condition:**  **Other relevant Medical History:**  **Patient aware of palliative diagnosis?** Yes / No  **Patient aware of referral and consents to their information being shared?**  Yes/No/Best Interests Decision | **Next of Kin/Primary Contact**  **Name:**  **Relationship (PoA or other):**  **Address:**    **Postcode:**  **Telephone:**  **Mobile:**  **Date of Birth:**  **NOK aware of palliative diagnosis?** Yes / No  **NOK aware of referral?** Yes / No  **Main Carer (if different to above)**  **Name:**  **Address:**  **Postcode:**    **Telephone:**  **Main contact details:** e.g. who to contact and how  **Carer aware of palliative diagnosis?** Yes / No  **Main Carer aware of referral?** Yes / No |

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| **Professionals’ Contact Details** |
| **GP Name:**  **GP Practice Address:**  **Telephone:**  **Is the patient on the Gold Standards Framework/ Palliative Care Register? Yes □ No □ Unsure□** |
| **Other Professionals (e.g. District Nurse, Specialist Nurse, Macmillan Nurse, Allied Health Professional)** |
| **Name: Title:**  **Location: Email:**  **Contact Numbers:**  **Name: Title:**  **Location: Email:**  **Contact Numbers:**  **Name: Title:**  **Location: Email:**  **Contact Numbers:** |

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| **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 □  Personal Care/Practical support □  Family/Carer Breaks and Support □  On Hold for future care □ | |
| **Priority of Referral**  **□ Priority 1** *urgent needs /rapid input required – rapid change in condition,* ***OR***  *complex symptoms in the last hours or days of life, rapid discharge, carer crisis, pre-admission – rapid response to need within 30 minutes -1hour*  **□ Priority 2** *high priority – deterioration in the last days or weeks of life,* ***OR*** *awaiting care package, potential breakdown foreseen, respite for carers – planned care respond to referral in 2 hours with a planned assessment within 24-48 hours*  **□ Priority 3** *routine priority- palliative and stable but with anticipated deterioration over coming weeks /months,* ***OR*** *carer breaks needed to sustain current level of help, help with personal care as dependency is increasing, preferred to stay at home- keep on hold for hospice at home care* | | |
| **Care Planning**  Are there anticipatory end of life medications in the home? Yes/No  Has Preferred Place of Care/ Death been discussed? Yes/No  *If Yes where is this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Does the patient have a DNaCPR? Yes/No  *If yes location of form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Applicable to Priority 1 and 2 referrals only* -Has the GP authorised Nurse Verification of Expected Death? Yes/No | | Is the patient in receipt of CHC fast track funding? Yes/No  Existing Care Package and Provider:  Is the care package funded by the Local Authority or the patient? (please provide details) |

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| **Care needs**  **Assistance required** | **Please provide details of need** | |
| **Personal care/Mouth care/Skin integrity/ Repositioning** |  | |
| **Nutrition/Hydration** |  | |
| **Medication management.**  **Symptom control/management?**  ***Medication route*** |  | |
| **Medication route** *e.g. Oral, patch, syringe drive, PEG* |  | |
| **Continence** | Is the patient incontinent of faeces/urine/both (please circle)  Incontinence products used? Y □ N □ Please state  Catheter in situ? Y □ N □ Reason for insertion  Date next catheter change due □ | |
| **Mental Health/ Psychological and Emotional support/ Communication** |  | |
| **Mobility/Safety.**  **Risk management.** |  | |
| **Additional needs?** |  | |
| ***Applicable For CHC fast track only*- Does the level of need indicate that a care home placement should be considered?** | **Yes** (please comment) | **No** (please comment) |

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| **Care Package Required** | | | | | | | | | | | |
| **Number of agency visits required per day?** | | **Number of agency carers required per visit?** | | **Length of homecare visits?**  *PLEASE DETAIL IN COLUMNS BELOW*  *(e.g 30mins /45mins/ 60mins)* | | **Number of District Nurse visits per day?** | | | **District Nurse interventions required?** | | |
| **08:00-**  **10:00** | **10:00-**  **12:00** | | **12:00-**  **14:00** | | **14:00-16:00** | | **16:00-18:00** | **18:00-20:00** | | **20:00-22:00** | **Night** |

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| **Informal/Family support**  *(Shopping, Meals, Who lives with or nearby, Friends support)* |
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| **Home Environment** | | | | | |
| Accommodation | House □ Bungalow □ Flat □ Warden Controlled □ Other □ | | | | |
| Detail any issues with access e.g. parking, key safe details, | | | | | |
| Additional relevant information e.g. Safety Factors for consideration, oxgen user etc. | | 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 | | | |  |  |

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| **Referrer’s Details** | |
| Name of Referrer |  |
| Title of Referrer |  |
| Organisation |  |
| Contact Number/Bleep |  |
| Email of Referrer |  |
| Signature of Referrer |  |
| Date of Referral |  |
| Is the referrer the professional main point of contact if further information is needed? | Yes/ No *if no please provide contact details of the professional who knows the person best:* |

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| **Referral Address** |
| **Please return to Ecccg.echospiceathome@nhs.net**  **Hospice at Home; 01625 664999** |
| **For Eastern Cheshire End of Life Care Hub use only** |
| Date/Time referral received …………………………………………………………………………………  NHS number …………………………………………………… EMIS number…………………………….  Referral received by …………………………………………Designation…………………………………  Time Actioned / Contact made with Referrer……………….…………………………………………………  Time of Contact with Patient/Family ……………………………………………………………………………  First assessment visit scheduled for (date)……………………………  Review date )…………………………… |