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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/NoHas 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/NoExisting 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 stateCatheter in situ? Y □ N □ Reason for insertionDate 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 )…………………………… |