*Respite Referral Form for Healthcare Professionals* 

1. **Patient Details**

**Name.....................................................................................DoB.......................................**

**Address...............................................................................................................................**

….................................................................................................................................................

**Telephone number.............................................Mobile Number........................................**

**Current location..................................................................................................................**

**Who does the patient live with?.........................................................................................**

**Ethnicity..............................................................Religion...................................................**

**Current registered GP.........................................................................................................**

**Consent to access shared EMIS record Y/N Patient agrees to referral Y / N**

1. **Carer details**

**Name...............................................................Relationship to patient...............................**

**Address...............................................................................................................................**

…................................................................................................................................................

**Contact telephone number(s)…..........................................................................................**

1. **Care needs**

**Details of any current care package in place......................................................................**

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**Is the patient highly dependent on their carer in the home setting? Please supply details**

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…..............................................................................................................................................

1. **Clinical information**

**Primary diagnosis……………………………………………………………………………………………………………..**

**Patient aware of diagnosis and prognosis?..........................................................................**

**Current/previous treatment?.............................................................................................**

……………………………………………………………………………………………………………………………………………….

**Medical history…………………………………………………………………………………………………………………..**

**……………………………………………………………………………………………………………………………………………..**

**Allergies……………………………………………………………………………………………………………………………….**

**Infection risks……………………………………………………………………………………………………………………….**

**Does the patient require any respiratory support** (e.g non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP), Continuous Positive Airway Pressure Ventilation (CPAP), oxygen, nebuliser) Y / N (please list if applicable) …................................................

….....................................................................................................................................................

**DNACPR form Y / N**

**Vaccinations: Influenza Y / N – date...................Covid-19 Y / N – date..............................**

**Is the person able to attend the hospice for a Covid-19 test 48hrs prior to admission? Y / N**

**Does the person have capacity to consent to admission? Y / N – if no, please give detail:**

**….........................................................................................................................................**

**Any other relevant information?.........................................................................................**

….................................................................................................................................................

1. **Respite request**

**Which week is requested?** (please note only 1 week can be requested at a time, Thursday

to Thursday, a maximum of 3 months in advance)...................................................................

**Is there an alternative week/flexibility in the dates? Y / N..................................................**

**Does the patient have their own transport to and from the hospice? Y / N** (if no, we request this is arranged and booked by yourselves)

**Is this respite request for:**

* **Carer break** **☐**
* **Rehabilitation goals**  **☐**
* **Advance care planning**  **☐**

1. **Referrer details**

**Signature:…..............................................................Name:................................................**

**Position:........................................................Contact details:…..........................................**

**Date of referral:**

**Upon completion, please email this form using NHS mail to** [**ecccg.echospicerespite@nhs.net**](mailto:ecccg.echospicerespite@nhs.net)

***For ECH use:***

***Date of receipt:*** ***By:*** ***EMIS record created:*** ***EMIS number:***