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| **East Cheshire Hospice @Home Referral Form** |
| **Section 1** |
| ***Patient Details***  **Name:**  **Address**:  **Telephone:**    **Date of Birth:**  **Current location:**    **Gender:**  **Religion:**  **Ethnic Group:**  **Does the patient live alone?** Yes / No (*Please inform the hospice at home team of key safe info)*  **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 |
| **Section 2** |
| ***Next of Kin/Primary Contact***  **Name & relationship:**  **Address:**  **Telephone:**  **NOK aware of palliative diagnosis?** Yes / No **NOK aware of referral?** Yes / No  ***Main Carer (if different to above)***  **Name & address:**  **Telephone:**  **Carer aware of palliative diagnosis?** Yes / No  **Main Carer aware of referral?** Yes / No |
| **Section 3** |
| ***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:** |
| **Brief summary of need and Patient/carer expectation: -** |
| **Section 4** |
| ***Reason for Referral*** (more than one choice acceptable)   * **Rapid Response OOH care support in last 3 months of life including crisis and psychological support *(please complete sections 1-6 & sections 10 & 11)***      * **Carer Breaks in the last 6 months of life/ad-hoc personal care/practical support *(please complete ALL sections)*** * **On Hold for future care *(please complete sections 1-6 & sections 10 & 11)*** |
| **Section 5** |
| ***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 – response to referral same day. Attendance response as soon as capacity allows, based on clinical assessment.*  **□ Priority 2** *high priority – deterioration in the last days / weeks of life,* ***OR*** *awaiting care package, potential breakdown foreseen, respite for carers – planned care. Response to referral same day and planned intervention within 24-48 hours if appropriate.*  **□ 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.* |
| **Section 6** |
| ***Care Planning***  **Is 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:** |

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| **Section 7** | | |
| ***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 □  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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| **Section 8** | | | | | | | | |
| ***Care Package Required*** | | | | | | | | |
| **Number of agency visits required per day?** | | **Number of agency carers required per visit?** | | **Length of homecare visits?** | **Number of District Nurse visits per day?** | | **District Nurse interventions required?** | |
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| **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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| **Section 9** |
| **Informal/Family support**  *(Shopping, Meals, who lives with or nearby, Friends support)* |
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| **Section 10** | | | | | |
| ***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, oxygen 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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| **Section 11** | |
| ***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** [**cmicb-cheshire.echospiceathome@nhs.net**](mailto:cmicb-cheshire.echospiceathome@nhs.net)  **Hospice @Home tel: 01625 664999** |
| ***For office use only*** |
| *Date/Time referral received …………………………………………………………………………………*  *NHS number …………………………………………………… EMIS number…………………………….*  *Referral received by …………………………………………Designation………………………………….*  *Contact made with referrer……………………………………………………………………………………*  *Contact with Patient/Family…………………………………………………………………………………..*  *First assessment visit scheduled for…………………………………………………………………………*  *Review date……………………………………………………………………………………………………..* |