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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)***

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| **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 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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| **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****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……………………………………………………………………………………………………..*  |