# East Cheshire Specialist Palliative Care Referral Form

1. **Patient Details**

Title: Surname: Forename(s): D.O.B: Age: *Sex:* M / F / Prefer not to say

Gender: M / W / Non binary / Prefer not to say / Other Does your gender match your sex at birth?: Y / N Comments NHS Number: Home Address: Postcode:

Home Phone: Mobile Phone: Lives Alone: Ethnicity: Religion: Current Location of patient (include ward if inpatient):

1. **NOK / Carers Details**

Name: Relationship to patient Address

Postcode: Home phone: Mobile phone:

1. **Community Health Care Professional Details**

GP Name: GP Practice: GP Phone: GP aware of referral: District Nurse Team/number Social Worker/number SPCN/number

1. **Hospital details**

Other Professionals Involved:

Hospital (1):

Consultant (1):

Hospital (2):

Consultant (2): Clinical Nurse Specialist: Location:

1. **Service Required (please select as required)**

***Macmillan Specialist Palliative Care Team Please Email*** [***ecn-tr.palliativecareteam@nhs.net***](mailto:ecn-tr.palliativecareteam@nhs.net) ***or for Macmillan Lung Cancer Nurse Specialists***

## [*ecn-tr.macmillanlungcancernurses@nhs.net*](mailto:ecn-tr.macmillanlungcancernurses@nhs.net)

Inpatient Hospital Review: 

Community Review: 

Palliative Medicine Consultant Outpatient Clinic:

***East Cheshire Hospice***

## *Email* [*cmicb-cheshire.echospiceipu@nhs.net*](mailto:cmicb-cheshire.echospiceipu@nhs.net)

Inpatient Admission

Action now  On hold  Is this referral for: Symptom Management:  Optimisation/Rehabilitation: 

End of Life Care: 

Sunflower Centre and Outpatient Services

[Email:***cmicb-cheshire.echospicesfc@nhs.net***](mailto:cmicb-cheshire.echospicesfc@nhs.net)Wellbeing assessment: 

Living Well:  Breathlessness programme: Lymphoedema assessment:  Art Psychotherapy:  Complementary Therapy:  Physio outpatient assessment: 

(for Community physio/OT, please refer separately to Community Rehab team,email: [ecn-](mailto:ecn-tr.communitytherapieseast@nhs.net) [tr.communitytherapieseast@nhs.net](mailto:ecn-tr.communitytherapieseast@nhs.net) )

**Separate referral forms for Respite, Blood transfusions, Dementia and MND Wellbeing can be found on the hospice website** [**www.eastcheshirehospice.org.uk**](http://www.eastcheshirehospice.org.uk/)[**un**](http://www.eastcheshirehospice.org.uk/)**der ‘Professionals’**

 

# East Cheshire Specialist Palliative Care

**Referral Form**

**Name of patient:**

1. **Clinical Information about the patient**

**DOB:**

**Primary diagnosis Date of diagnosis Site of metastases Date of diagnosis Treatments / dates Significant PMH Other relevant information Allergies**

**Infection risk Patient understanding of illness NoK understanding of illness**

1. **Advance Care Planning / other discussion Resuscitation discussions and outcome:**

uDNR-CPR form completed and with patient:  Internal cardiac defibrillator (ICD)/ pacemaker insitu:  Patient Preferred Place of Care (PPC): Preferred Place of Death (PPD): Continuing Health Care (CHC) Funding Approved:

Are the patient and their NOK aware of this referral? Patient: NOK:

Has the Patient given consent for health / social care staff involved in their care / treatment to view their health records: Y / N

**Current Situation and reason for referral to Specialist Palliative Care:**

**Phase of Illness:**

**Please Indicate on Karnofsky Performance Scale the Current Status of the Patient:**

|  |  |
| --- | --- |
| Normal; no complaints; no evidence of disease | 100 |
| Able to carry on normal activity; minor sign of symptoms of disease | 90 |
| Normal activity with effort; some signs or symptoms of disease | 80 |
| Cares for self; unable to carry on normal activity or to do active work | 70 |
| Able to care for most needs; but requires occasional assistance | 60 |
| Considerable assistance and frequent medical care required | 50 |
| In bed, more than 50% of the time | 40 |
| Almost completely bedfast | 30 |
| Totally bedfast and requiring extensive nursing care by professionals and/or family | 20 |
| Comatose or barely rousable | 10 |

**Referrers Name: Contact Number**

Designation: Date:

***Specialist Palliative Care Team (9am-5pm Monday-Friday) Tel 01625 663177 Macmillan Lung Cancer Team (9am-5pm Monday-Friday) Tel 01625 661997***

***Bleep via MDGH Switchboard for Urgent Advice 9am-5pm Monday-Friday 1004 (9602 for Lung Cancer Patients) East Cheshire Hospice 24 hr Advice line 01625 666999***