**EMAIL REFERRAL FORM FOR ALL ORGANISATIONS**

**Email to East Cheshire Hospice @Home Team:**

[**cmicb-cheshire.echospiceathome@nhs.net**](mailto:cmicb-cheshire.echospiceathome@nhs.net)

**The Hospice @Home team will contact you to acknowledge receipt of your referral and to confirm if care has been booked. If you have any questions and would like to speak to a coordinator, please call: 01625 664999**

**Please ensure that all details are added to the form in order to avoid a delay in the referral being processed.**

**Throughout the form items marked \* are mandatory fields therefore must be completed.**

**\*Is the Patient aware of this referral? Choose an item.**

**\*Is the Next of Kin aware of this referral? Choose an item.**

**Every patient registered will receive an Introductory “Welcome” pack which will be posted the next working day.**

***Please ensure referrer and patient have phone number of the Hospice @Home Team 01625 664999 and Marie Curie Co-ordination Hub - 0151 541 7808***

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| **Blue text on a black background  Description automatically generated**Logo  Description automatically generated  **Marie Curie Referral form**  **Referrer name** (Registered Professional):  **Role:**  **Contact details:**  **Name** if completing on behalf of registered professional:  Please complete **all sections** to ensure the patient can be registered and enable Marie Curie to provide care as requested. | |
| **Patient Registration** | |
| **Primary details** | |
| **Title** | Choose an item. |
| **Given name** (First Name) |  |
| **Known as** |  |
| **Family name** (Surname) |  |
| **Gender at birth** | Choose an item. |
| **Date of Birth** (dd/mm/yyyy) |  |
| **Health Care Number (**CHI/H&C/NHS) |  |
| **CHC Number (if applicable to service)** |  |
| **Patient’s main language** |  |
| **Patient’s contact details** | |
| **Full address** including postcode |  |
| **Access instructions** e.g., key safe code |  |
| **Home number** |  |
| **DN details** | |
| **Name** |  |
| **In hours contact number** |  |
| **Out of hours contact number** |  |
| **GP details** | |
| **Title** | Choose an item. |
| **GP practice name & address** |  |
| **What area are you referring from?** |  |
| **Next of Kin details** | |
| **What is their relationship to the patient?** | Choose an item.  Other: |
| **Title** | Choose an item. |
| **Family name** (Surname) |  |
| **Given name** (First Name) |  |
| **Home number** |  |
| **Mobile number** |  |
| **Are they an emergency contact?** | Choose an item. |
| **Can we discuss the patient’s record with this individual?** | Choose an item. |
| **Are they a Carer?** | Choose an item. |
| **If no, and there is a Carer, please provide details.** |  |
| **Referral Information (This template is mandatory, please complete all fields where appropriate for a safe referral)** | |
| **Priority of care level (refer to Appendix A)** | Choose an item. |
| **Patient diagnosis?** | Choose an item.  Other: |
| **Marital status** | Choose an item. |
| **Ethnicity** | Choose an item. |
| **Religion** | Choose an item.  Other: |
| **Referral to which service** |  |
| **Locality (geographical)** |  |
| **Location of patient at referral** | Choose an item. |
| **Patient Lives with?** **Please add further information to assist with understanding who they live with including names, relationship, are they involved with supporting the patient/involvement in care delivery and how they are managing.** | Choose an item.  Further information: |
| **Is there a care plan in the patient’s home?** | Choose an item.  Comments: |
| **Package of care requested** | Choose an item. |
| **Number of day hours per week requested.** |  |
| **Number of nights hours per week requested.** | Choose an item. |
| **Advance care planning** | |
| **What is the patient’s** **DNACPR status?** | Choose an item. |
| **Where can the team view DNACPR documentation?** |  |
| **Where is the patient preferred place of care?** | Choose an item. |
| **Where** **is the patients preferred place of death?** | Choose an item. |
| **Clinical information** | |
| **Any known allergies? If yes, please specify** | Choose an item.  Please specify: |
| **Patients’ current symptoms and how are they being managed?** | **Please select symptoms that apply:**  **Shortness of breath**  Additional information:  **Pain**  Additional information:  **Respiratory symptoms**  Additional information:  **Lack of energy**  Additional information:  **Change in appetite**  Additional information:  **Constipation**  Additional information:  **Agitation or anxiety**  Additional information:  **Confusion**  Additional information:  **Nausea or vomiting**  Additional information:  Other: |
| **Describe level of consciousness.** | Choose an item.  Comments: |
| **Does the patient have the capacity to Consent to treatment and care?** | Choose an item.  Comments: |
| **Are there any other health conditions that may affect their care? (i.e.,** **cognitive impairment, current infections e.g. MRSA, dementia, learning difficulties)** |  |
| **Does the patient have anticipatory medicines and administration chart in place?** | **Both medicines and chart in place**  **Only medicines in place**  **Only chart in place**  **No**  Comments: |
| **Is there syringe driver in situ?** | Choose an item.  Comments: |
| **Who is aware of the diagnosis?** | **Patient**  **Family**  **Carer**  Comments: |
| **Patient prognosis?** | Choose an item. |
| **Who is aware of the prognosis?** | **Patient**  **Family**  **Carer**  Comments: |
| **Patient mobility?** |  |
| **Does the patient have history or risk of falls?** | Choose an item.  Comments: |
| **Has a falls risk assessment been carried out?** | Choose an item. |
| **If yes, are there any specific requirements? e.g., observations, bed rails, sensor pads, crash mats etc** | Choose an item.  If yes to any, please update: |
| **Is the patient experiencing any incontinence?** | Choose an item.  Comments: **E.g., catheter, incontinence pads** |
| **Is there a hospital bed in situ?** | Choose an item.  Comments: |
| **Does the patient have any skin damage or pressure ulcer?** | Choose an item.  If yes, please elaborate: |
| **Where appropriate please ask for International Dysphagia Diet Standardisation Initiative scoring (IDDSI) and ensure you select both for fluid and diet.** | Thin fluid (IDDSI score 0)  Slightly thick fluid (IDDSI score 1)  Mildly thick fluid (IDDSI score 2)  Moderately thick fluid (IDDSI score 3)  Extremely thick fluid (IDDSI score 4)  Liquidised food (IDDSI score 3)  Pureed food (IDSSI score 4)  Minced and moist (IDDSI score 5)  Soft and bite sized food (IDDSI score 6)  Regular, easy to chew (IDDSI score 7)  Unable to swallow  PEG feeding  Nasal Gastric Tube (NG tube)  Comments: |
| **Accessible Communication** | |
| **Does the patient have any accessible communication needs?** | No known disability  Patient reports no current disability  Hearing loss  Visual impairment  Difficulty communicating  Does not speak English  English language interpreter needed  Impaired cognition  Impaired ability to recognise safety risks  Unable to summon help in emergency  Comments: |
| **Does the carer have any accessible communication needs?** | No known disability  Hearing loss  Visual impairment  Difficulty communicating  Does not speak English  English language interpreter needed  Impaired condition  Impaired ability to recognise safety risks  Unable to summon help in emergency  Comments: |
| **Home Visit Risk Summary** | |
| **Do they have complex handling needs? prompt- is the patient bariatric, do they need hoist support? Any other patient handling equipment.** |  |
| **Is a double handed visit needed?** | Choose an item.  If yes, reason why: |
| **Are there any pets in the home?** | Choose an item.  If yes, what type of animals: |
| **Does smoking take place in the home (family or patient?) If yes, please state what is smoked, by whom and where in the house.** | Choose an item.  Comments: |
| **Does the patient have a home oxygen supply?** | Choose an item.  Comments: |
| **Are there any hazards identified outside of the property? For example, uneven surfaces, lighting, restricted space.** | Choose an item.  Comments: |
| **Are there any known physical hazards within the home that could affect safe care delivery?**  **(e.g., uneven surfaces, heating, lighting, restricted space)** | Choose an item.  Comments: |
| **Are supplies required for the care and handling plan in the home?**  **For example, gloves, aprons, slide sheets, hoists, etc.** | Choose an item.  Comments: |
| **Does patient or carer’s behaviour alter dramatically? E.g., Delirium. If yes, please answer further question below** | Choose an item.  Comments: |
| **Is there any risk of aggression?** | Choose an item.  Comments: |
| **Are there any safeguarding concerns relating to the patient?** | Choose an item.  Comments: |
| **Has any agency ever refused care or have any additional safety measures been introduced? e.g., two-person visit?** | Choose an item.  Comments: |
| **Does patient or any household member have confirmed or suspected Covid-19?**  **Awaiting test result for patient/household member?** | Choose an item.  If yes, what date did they test positive? |
| **Please detail if the patient or household members use an Aerosol Generating Procedure e.g., respiratory tract suctioning, tracheostomy procedure** | Choose an item.  Comments: |
| **Patient Information Pack required? A pack should be requested for patient requiring night and day visits.** | Choose an item. |
| **Is there any additional information that we should be made aware of?** |  |

**APPENDIX A**

Please use the following categories to assess the patient’s **priority of care level.** (This assessment should be made by the District Nurse).

