**EMAIL REFERRAL FORM FOR ALL ORGANISATIONS**

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

**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).

