**This form is only for use when referring PCIP patients to the Hospice @Home Team for a package of care.**

**CRITERIA FOR PCIP REFERRAL**

1. Patient is rapidly deteriorating and entering a terminal phase of illness
2. Requires an urgent\* package of care to **remain at home**
3. Wishes to be cared for & die at home

 **ALL criteria above to be met prior to referral.**

Hospice @Home (Palliative Care in Partnership) contact details: Tel - 01625 664999

H@H Co-ordination Monday – Friday, 9 - 5pm

H@H Team and Rapid Response Monday – Sunday, 9pm – 8am

**Once completed, please email this form to: cmicb-cheshire.echospiceathome@nhs.net**

|  |  |
| --- | --- |
| Patient meets criteria for PCIP | Y / N |
| Patient Name  |  |
| D.O.B.  |  |
| NHS number:  |  |
| GP contact details: |  |
| Permanent address and telephone number | Home addressPatient Home Telephone Patient Mobile Telephone  |
| * Next of kin/primary contact
* NOK aware of referral and diagnosis:
 | Name:Relationship:Telephone:Address:Y / N |
| * Does patient live alone?
* Is patient aware of palliative diagnosis?
* Diagnosis/medical condition

Current location * Access details
 | Y / NY / N………………………………………………………….[ ] Hospital [ ] Home [ ] Hospice [ ] other…………………………………………….………………………………………………………… |
| * Has an acute treatable cause been ruled out?
* Please give brief outline of prognosis/evidence of rapid deterioration:
 | Y / N |
| Gender- Sex-Religion- |  | Any other special needs that should be considered? |  |
| Patient has given consent for referral to PCIP | Y / N |
| Patient is on GP Practice Gold Standards Register (Seen by referring clinician and documented on EMIS) | Y / N |
| Patient has an EPaCCs record that shows discussion & recording of:* Advanced Care Planning
* CPR Status
* Preferred Place of Care
* Preferred Place of Death
 | Y / NY / NY / NY / N |
| GP Out of Hours notified of accepted patient as an expected death (POC) | Y / N |
| -Informal/family support: (shopping, meals, who lives nearby) | Y / N……………………………………………………………………………………………….. |
| Care plan completed for PCIP  | Y / N (please add information below) |
| Name, job title and contact details of referring clinician |  |

***PATIENT CARE PLAN:*** *T*o include details onnutrition, hydration, personal care, medication management, continence, mental health, mobility, additional needs etc.

|  |  |
| --- | --- |
| **Care needs****Assistance required** | **Please provide details of need** |
| **Personal care/Mouth care/Skin integrity/ Repositioning** |  |
| **Nutrition/Hydration** |  |
| **How will the patient take their medication?****Who supports the patient with their medication?****Symptom control/management?** |  |
| **Continence** | Is the patient incontinent of faeces **Y / N**Is the patient incontinent of urine **Y / N**Incontinence products required? **Y / N** Please state:Catheter in situ? **Y / N** Reason for insertion:Date next catheter change due dd/mm/yyyy |
| **Mental Health/ Psychological and Emotional support/ Communication** |  |
| **Mobility/Safety****Risk management** |  |
| **Additional needs?** |  |
| **Does the level of need indicate that a care home placement should be considered?** | **Yes (please comment)** | **No (please comment)** |
| **Care Package Required** |
| **Number of care visits required per day** | **ONE TWO THREE FOUR NIGHT CARE** |
| **Number of Health Care Assistants required per visit** | **ONE TWO**  |
| **Length of visit required**  | ***30mins 60mins*** |
| **Are District Nurses involved?** | **Y / N** |
| **Are SPCT involved?** | **Y / N** |
| **8 am –** **10 am****Y / N** | **10 am – 12 noon****Y / N** | **12 noon – 2 pm****Y / N** | **2 pm –** **4 pm****Y / N** | **4 pm –** **6 pm****Y / N** | **6 pm –** **8 pm****Y / N** | **8 pm –** **10 pm****Y / N** | **Night Care?****Y / N** |
| **Night Care Requirements** (all/part night, purpose, single or double handling etc.) |  |