**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 address  Patient 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 / N  Y / 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 / N  Y / N  Y / N  Y / 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.) | | | | |  | | | | |