BUCKINGHAMSHIRE PALLIATIVE CARE REFERRAL FORM

via SINGLE POINT OF ACCESS - FINAL VERSION 11.06.2018

(Please ensure that ALL parts of this form are completed in FULL before submitting to SPA)
If referral form is incomplete it will be returned for further information and no action will be taken until it is returned successfully completed.

SURNAME **Age** **DoB**		**Male** ☐ **Female** ☐
FIRST NAME **Known as**		**Marital Status**
ADDRESS **POSTCODE** **Email**		**PRIMARY DIAGNOSIS** **DATE of DIAGNOSIS** **DATE of REFERRAL**
HOME Tel **MOBILE Tel**		**NHS number**
MAIN CARER: **Relationship to patient** **Tel**		
NEXT of KIN (if different from above): **Relationship to patient** **Tel**		
Who does the patient live with? Main Language? Interpreter needed?		**Ethnicity** **Religion**
GP NAME **Is GP aware of referral? Yes/No**	**Tel** **Email**	**Surgery**
KNOWN TO DISTRICT NURSE? Yes/No	**Tel** **Email**	**Based at**
OTHER PALLIATIVE CARE SERVICE INVOLVED?	**Name of Specialist Nurse**	**Tel** **Email**
Patient aware of diagnosis? Yes/No **Family aware of diagnosis? Yes/No**		**Continuing Care Assessment completed** **Yes / No / Don't know**
Does the patient consent to their information being shared with other palliative and healthcare providers? Yes/No **Has the patient consented to referral to Specialist Palliative Care? Yes/No** **Is this a best interest decision? Yes/No**		
Have any advance care planning discussions taken place? If yes, what outcomes **Is DNACPR completed? Yes/No** **Does the patient have an Advance Care Plan (as part of Bucks CCGS primary care EoL scheme?)** **Has the patient consented to record sharing through Summary Care Record Additional (SCR+)**		
Current location of patient – *please* ✓		
☐ **Hospital (acute, community, other)**	☐ **Hospice (inpatient specialist palliative care)**	
☐ **Care home**	☐ **Other residence (e.g. relative's home, carer's home)**	
☐ **Patient's own home**	☐ **Other (free text, e.g. secure and detained settings)**	

BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS		
Date	History, tests and treatment	Consultant and hospital

MRSA Status	**C. Diff Status**	**Other infection**	**PATIENT MOBILITY**

WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?

PRIORITY OF RESPONSE (Please delete as appropriate): URGENT SOON ROUTINE

PLEASE SEND GP SUMMARY, COPIES OF RECENT CLINICAL LETTERS AND CURRENT MEDICATION LIST

Does the patient have pressure ulcers? Yes/No If Yes, specify grade

Main Reasons for Referral - *please* ✓		**Service requested - *please* ✓**		**Provider requested - *please* ✓**	
Symptom control	☐	**Hospice Admission**	☐	**FNH**	☐
Medical intervention e.g transfusion	☐	**Community Team**	☐	**Nightingale 24/7**	☐
Psychological support	☐	**Day Hospice**	☐	**South Bucks CNS Team**	☐
End of Life Care	☐	**Lymphoedema**	☐	**Rennie Grove Hospice at Home** (South Bucks / Wycombe / Ridgeway)	☐
Respite	☐	**Physio / OT**	☐	**South Bucks Community Hospice**	☐
Other (please specify)	☐	**Medical OP / DV**	☐	**Sue Ryder Nettlebed Hospice**	☐
		Hospital Team	☐	**Hospice of St Francis**	☐
		Breathwell Group (DWP)	☐	**Thames Hospice**	☐
		In reach team	☐	**Bucks Hospitals Teams**	☐
				Marie Curie (alternative form required)	☐

PREFERRED PLACE OF CARE / DEATH: Home / Hospice / Hospital / Unknown / Other (Please specify)

REFERRER DETAILS

Name: **(Please print)**		**Routine Telephone No:**	
Job Title:		**Priority Contact No** (for a **minimum** of **2 hours** following **ANY Urgent** Referral being made via SPA)**:**	
Organisation:		**E-mail address (to ensure you receive confirmation of your referral):**	

Already Discussed Referral with Provider? Yes / No

Details of discussion: