NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Buckinghamshire PEoLC Single Point of Access
Palliative Care Referral Form

Referral Template for referrers in Buckinghamshire

V 2 EMIS Web
Approved by BOB ICB [March 2024]
Approved by BBO LMC [March 2024]
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Contact Details for service

Telephone	01296 321341	Please send completed referrals to **buc-tr.fnhspa@nhs.net** via secure email. (this email is not for patient use) SPA aim to review and triage referrals within 24 hours, Monday-Friday.** If the referral is urgent and requires more immediate attention, please also phone the number provided to discuss the referral.

Please send this referral form and where possible, please also attach other relevant information e.g. GP medical summary, ACP, ReSPECT form, clinic letters, discharge summaries, and investigation results as attachment via eRS.

If you are unsure about the need for Buckinghamshire Palliative and End of life care services or require advice, please call 01296 321341 to discuss

If the referral form is insufficiently complete, it may be returned for further information, and no action will be taken until requested fields are actioned.

Exclusion Criteria

- Patients under the age of 18
- Patients not registered with a GP in Buckinghamshire

Patient's Details				Patient's Background and Culture	
Forename				Ethnicity	
Surname				1st Language	
Known as				Interpreter Required?	Y ☐ N ☐
DOB		Age		**GP Details**	
Sex		Title			
NHS No				Referring GP	
Address & Postcode				GP Address	
Hosp No				GP Tel No	
Email				Practice Email	

Title **Given Name** **Surname** NHS Number Date of Birth

If you have a problem completing this pro forma please email us at bobicb.gpproformas@nhs.net
Do NOT send referrals or patient details to this email address

Phone Numbers		Preferred Number(s)	Can leave messages?	Patient may be consulted by telephone?
Home		☐	☐	☐ **Yes**
Work		☐	☐	☐ **No, if no please advise why**
Mobile		☐	☐	

Referral Dates	
Referral Date	
Date Received	
Referring Agent	GP ☐ DN ☐ PN ☐ Other ☐
Name of Referrer if not GP	
Contact information of referrer (if not GP)	

Carers / Parents / Guardians / Contacts	
Next of kin (and relationship to patient)	
Next of kin contact details	
Family aware of diagnosis?	Yes ☐ No ☐ Unknown ☐

Referral Indication			
Main reason for referral [Select all that apply] **Mandatory*	☐ Symptom Control ☐ Medical intervention e.g. transfusions ☐ Psychological support ☐ End of life care ☐ Other	**Service requested** **Mandatory*	☐ Hospice Inpatient ☐ Hospice at Home ☐ Community Team ☐ Medical Outpatient ☐ Day Hospice ☐ Lymphoedema ☐ Physio/OT ☐ Other [please specify]
Priority of response required **Mandatory*	☐ **Urgent Unstable/Dying** – needs response within 24 hours ☐ **Routine Deteriorating** - needs response within 1 week ☐ **Routine Stable** - needs response within 2 weeks		

DIAGNOSIS / REFERRAL INFORMATION			
Primary diagnosis	Enter text here	**Co-morbidities:**	
Does patient have a ReSPECT form/DNACPR?		**Has the patient consented to record sharing**	
Does the patient have cognitive impairment?	☐ Yes ☐ No If yes, please specify:	Is this a best interest decision?	☐ Yes ☐ No
What is the patients preferred place of care/death?	Home ☐ Hospice ☐ Hospital ☐ Unknown ☐ Other, please specify		

Referral Narrative

Title **Given Name** **Surname** NHS Number Date of Birth

(Please highlight any significant comorbidities)	
☐	**Please tick here if you are sending any additional documents**
☐	**Please tick here if the narrative of your referral is in merged consultations below**
Please type a brief reason for the referral here.	

NOTE: Please let us know if the patient will attend with an escort, and if so give the reason.

Biological data that are valuable for triage and assessment		
Required Data	**Data (Auto populated)**	**Data (Manual entry)**
Date of diagnosis		
Relevant investigations including details of any disease progression		
Details of any previous treatment		
Details of current treatment plan		
Details of care plan		

Patient Narrative (Please select relevant scores)			
Phase of illness (optional)	☐ Stable: Patient problems and symptoms are adequately controlled ☐ Unstable: An urgent change in the plan of care or emergency ☐ Deteriorating: Requires periodic review, because the patients overall functional status declines ☐ Dying: Death is likely within days ☐ Not known	**Frailty score** (auto-populate)	
Performance status AKPS (optional)	☐ 100%: Normal, no complaints ☐ 90%: Normal activity, minor signs symptoms ☐ 80%: Normal activity with effort, some signs of symptoms ☐ 70%: Cares for self, unable to carry on normal activity ☐ 60%: Occasional assistance required ☐ 50%: Considerable assistance/medical care required ☐ 40%: In bed for more than 50% of the time ☐ 30%: Almost completely bedfast ☐ 20%: Totally bedfast, requiring extensive care ☐ 10%: Comatose/barely arousable ☐ 0%: Dead		

	☐ Not known

Consultations

Problems

Medication

Allergies

FOR SPA TRIAGE PURPOSES ONLY *(primary care please do not complete)* *For triage administration, enter information requested. To check fields - double click on the grey box and select 'checked'*	
Date referral received by SPA:	
Date of triage:	
Referral sent to:	☐ Florence Nightingale ☐ Rennie Grove Peace ☐ Hospice of St Francis ☐ Thames Hospice ☐ South Bucks Hospice ☐ Other, please specify
Date onward referral made:	
To be booked for:	☐ Hospice Inpatient ☐ Hospice at Home ☐ Community Team ☐ Medical Outpatient ☐ Day Hospice ☐ Lymphoedema ☐ Physio/OT ☐ Other, please specify
Referral status:	☐ Accepted ☐ Rejected ☐ Further information requested
Continuing Care Assessment completed:	☐ Yes ☐ No ☐ In progress ☐ Done know
Additional information/comments	