

**Salisbury Hospice**

**Specialist Palliative Care Referral Form**

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| **To help us respond appropriately, please complete all sections of the form with as much detail as possible. Please attach any relevant supporting information. Missing information may potentially delay the processing of the referral.**  **For us to accept this referral, patient consent and sharing information with other Health and Social care services must be obtained.** |
| **If the referral is urgent, please also phone Salisbury Hospice on 01722 425113** |

**Patient Details:**

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| --- | --- | --- |
| Title: | First Name: | Surname: |
| DOB: | NHS Number: | Hospital No: |
| Home Number: | Mobile Number: | Current Location: |
| Address: | | |
| Lives Alone: Yes  No | | |
| Any communication difficulties: Yes  No  Details: | | |

**Main Carer Details:**

|  |  |
| --- | --- |
| Name: | Relationship: |
| Address: | Telephone Number: |
| Are they the first point of contact? Yes  No | |

**GP and other healthcare professionals involved:**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: | | Surgery: | |
| Is GP aware of referral? Yes  No | | Are District Nurses aware of referral? Yes  No | |
| Consultant: | Hospital: | | Telephone No: |

**Referrer Details:**

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| --- | --- |
| Referrer Name: | Referrer Position: |
| Referrer Base: | Referrer Telephone No: |
| Date of Referral: | |

**Referral Priority:**

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| --- | --- | --- |
| **ROUTINE**  Contact within 10 working days | **SOON**  Contact within 5 working days | **URGENT**  Contact within 1 -2 working days |
| Has the patient consented to this referral?  Yes  No | Has the patient consented to share their electronic records?  Yes  No | Is the NOK aware of the referral?  Yes  No |
| Can the patient be seen as an Outpatient? Yes  No | | |

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| Military Service Person  Military Veteran  Member of a Military Family |

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| **Diagnosis:** (primary diagnosis – including metastases, complications, and relevant treatment)  Please attach most recent/relevant correspondence. |
| Please summarise current problems and specific aims of referral to the Specialist Palliative Care Team: |

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| **REASON FOR REFERRAL:** | **SERVICES REQUIRED:** |
| Uncontrolled Symptoms | Community Team |
| Emotional/Psychological/Spiritual Support | Peter Gillam Support Centre |
| Family / Carer Support | Assessment for IPU admission |
| Advice with Future Care Planning | Outpatient Appointment |
| Introduction to Service |  |
| Urgent End of Life Care  ***Please refer Urgently to District Nursing Service*** | |

**Advance Care Planning:**

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| Does the patient have a ReSPECT form? Yes  No |
| What is their Treatment Escalation Plan? Please include Resuscitation status: |
| Is Just in Case medication prescribed? Yes  No |
| Preferred place of DEATH Home  Hospice  Hospital  Unknown |

**Additional Information:**

|  |  |
| --- | --- |
| Detail any supportive interventions, e.g., RIG/PEG feeding; NIV, oxygen: | |
| Mobility/Disability Issues: | Equipment Needs: |
| Care Package in place? Yes  No | |
| Care Package CHC funded? Yes  No  If **NO** has CHC been applied for? Yes | |
| Are there any Lone Worker risks that may affect safety? – e.g., home environment, patient, family, pets:  Yes  No  If Yes, give details: | |

**Medical Problems:**

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**Allergies:**

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**Medication:**

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**Our preferred method of referral is through SystmOne, however it can be emailed to this location:** [**shc-tr.salisbury-rapidreferralcentre@nhs.net**](mailto:shc-tr.salisbury-rapidreferralcentre@nhs.net)

**Phone: 01722 425113**