CONFIDENTIAL REFERRAL FORM

St Ann's Hospice provides care for patients with life limiting illness who have complex needs and who require assessment and management by the hospice multi-disciplinary team. St Ann's Hospice **cannot provide indefinite care**. We would request that prior to referral, you give due thought as to whether the hospice is the most appropriate place to meet your patient's needs.

Full completion of St Ann's Hospice Referral Form is a requirement when requesting access to services. Clarity of information assists us in providing a timely response to your request for services, therefore, we would ask that you provide clear, concise and relevant information to assist us in the processing of your request. **Incomplete forms will be returned** for completion and this will regrettably have an impact on the speed of access to our services.

INPATIENT CARE

Patients will be admitted for a period of ongoing assessment and the patient's condition and care needs will clearly determine the length of stay.

DAY THERAPY

This is an umbrella title for Day Care, Palliative Medical Outpatients and Supportive Outpatients.

Day Care: Patients attend for approximately 12 weeks for assessment, support and rehabilitation thus enabling them to continue living at home as long as possible. Assessment and review are ongoing and the patient's condition will clearly determine future support and care needs whether that be via hospice services or in the community.

Palliative Medical Outpatients: Patients are referred for support in managing complex pain and symptom control.

Community Specialist Palliative Care Team: The Community Specialist Care Team (CSPCT) provides specialist assessment in the patient's current place of residence and agrees an appropriate management plan with the patient.

'St Ann's Hospice at Home': The service provides practical support and nursing care for patients with a life-limiting illness, especially when the patient is approaching the end of their life.

Supportive Outpatients: Patients and Carers are referred or may self refer for support with coping with a life-limiting illness. Following a key worker assessment, a programme of interventions is planned to help with meeting agreed goals. (See below)

The criteria for accessing all of St. Ann's Services are detailed in the referral handbook and are also available on the St Ann's Hospice website www.sah.org.uk/referrals

St Ann's Hospice
St Ann's Road North
Heald Green
Cheadle
Cheshire
SK8 3SZ

Tel: 0161 437 8136
Fax: 0161 498 9640

St Ann's Hospice
Meadowsweet Lane off Peel Lane
Little Hulton
Worsley
Manchester
M28 0FE

Tel: 0161 702 8181
Fax: 0161 790 0186

Neil Cliffe Centre
Wythenshawe Hospital
Southmoor Road
Manchester
M23 9LT

Tel: 0161 291 2912
Fax: 0161 291 2968

SUPPORTIVE OUTPATIENTS

These are held at each of the 3 hospice sites. On the first visit the patient will be assessed by a keyworker. Listed below are the interventions available

Heald Green

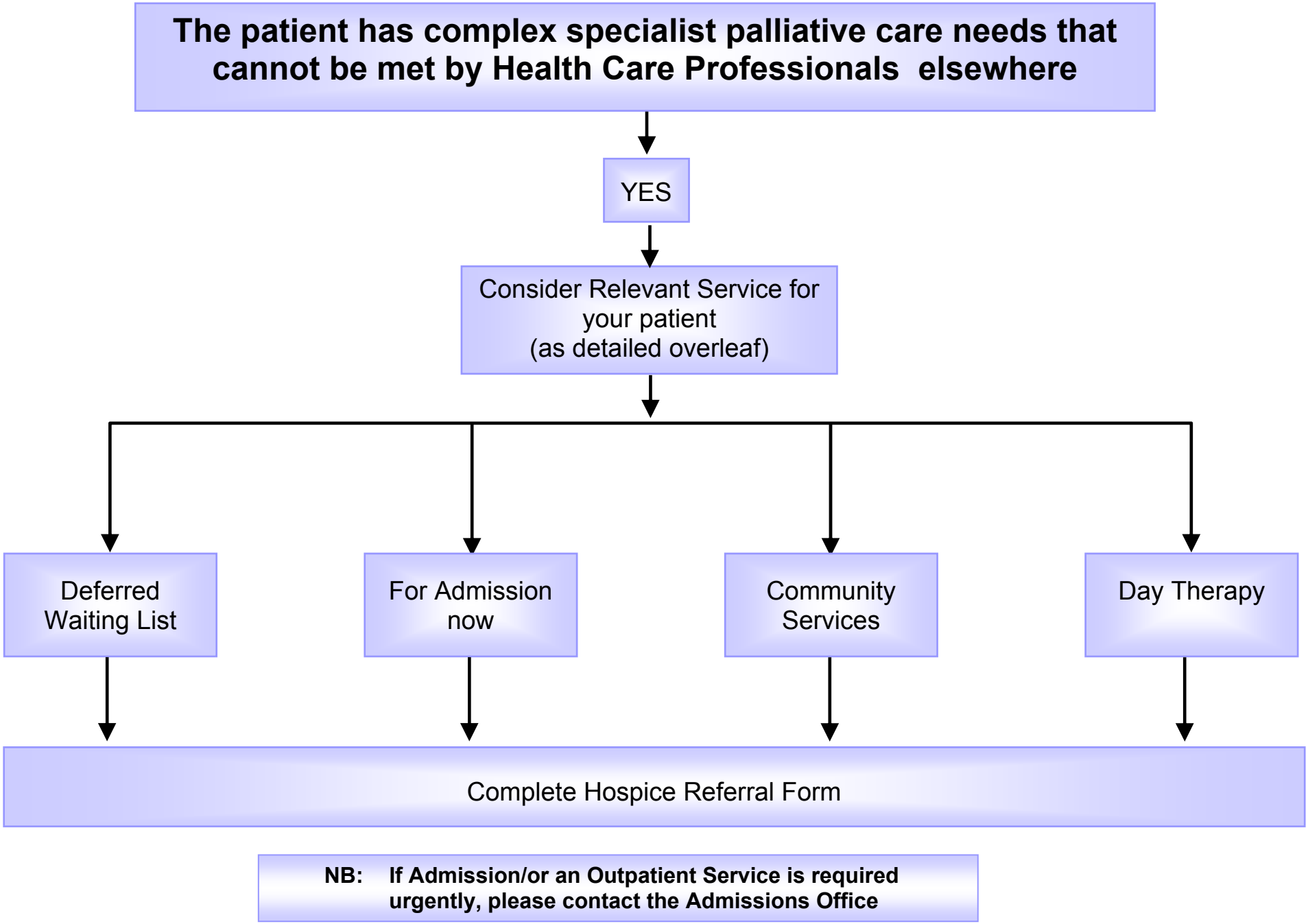
Counselling
Lymphoedema Management Clinic
Palliative Medical Outpatients
(See Neil Cliffe Centre for other Services)

Little Hulton

Breathlessness Management
Complementary Therapies
(Aromatherapy, Reflexology, Reiki,
Indian Head Massage)
Counselling
Dietetic Management
Lymphoedema Management Clinic
Palliative Medical Outpatients
Occupational Therapy Assessment
Physiotherapy Assessment
Creative Art Therapy
Relaxation (Taught skills group)
Anxiety Management
Hypnotherapy
Fatigue Management Group
Social & Welfare Advice
Body Image

Neil Cliffe Centre

Breathlessness Management
Complementary Therapies
(Aromatherapy, Reflexology, Reiki,
Indian Head Massage)
Counselling
Dietetic Management
Palliative Medical Outpatients
Occupational Therapy Assessment
Physiotherapy Assessment
Depression & Anxiety Management
Relaxation (Taught skills group)
Fatigue Management Group
Symptom Control (Physiotherapy led clinic)
Social & Welfare Advice
Survivorship Skills
Body Image
Spiritual Support
Psychological Support


The patient has complex specialist palliative care needs that cannot be met by Health Care Professionals elsewhere
YES
Consider Relevant Service for your patient (as detailed overleaf)
Deferred Waiting List
For Admission now
Community Services
Day Therapy
Complete Hospice Referral Form
NB: If Admission/or an Outpatient Service is required urgently, please contact the Admissions Office

Patient Details

Surname: _____ Forename: _____ Title: _____ Sex: _____

DOB: _____ Age: _____ Marital Status: _____ Occupation: _____ Religion: _____

Home Address: _____ **NHS No.:**

Post Code: _____ Tel. No.: (Home): _____ (Work) _____ (Mobile) _____

Next of Kin Details

Name: _____ Relationship to Patient: _____

Main Carer

Name: _____ Relationship to Patient: _____ Tel. No.: _____
(If different from NOK)

Address: _____ Post Code: _____

Tel No. (Home): _____ (Work): _____ (Mobile): _____

Location of Patient

(at time of referral) Home: ☐ Hospital: ☐ Nursing/Residential Home: ☐

Name of Hospital / Care Home: _____ Ward: _____ Tel No.: _____ Contact Person: _____

Has the patient been informed of this referral?: **YES** ☐ **NO** ☐

If not, please explain why: _____

Service Required

Heald Green ☐ Little Hulton ☐ Neil Cliffe Centre ☐

In Patient
(Heald Green & Little Hulton Only)

- Admission Required ☐
- Admission Not Yet Required (for information only) ☐

Day Therapy

- Palliative Medical Outpatients ☐
- Day Care ☐
- Lymphoedema Management ☐
- Supportive Outpatients ☐
- Breathlessness Clinic ☐

Community Support
(Salford)

- Specialist Palliative Care Nurse ☐
- Specialist Palliative Care Social Worker ☐
- Specialist Pallaitve Care Occupational Therapist ☐

(Salford & Trafford only)

- St Ann's Hospice at Home ☐

Reason for Referral

_____

Medical Details

Primary diagnosis & Histology: _____ Date of Diagnosis: _____

Site(s) of Metastases: _____

Relevant investigations/Surgery/Radiotherapy/Chemotherapy (dates): _____

_____

Hospital Attended: _____ Hospital No.: _____ Consultant(s): _____

Hospital Attended: _____ Hospital No.: _____ Consultant(s): _____

Current clinical situation: _____

Pain sites and severity: _____

Any other symptoms: _____

Co-existing Medical conditions: _____

Current Medication: _____

_____

Has patient an Internal Cardiac Defibrillator/Pacemaker? PLEASE SPECIFY: _____

Is the patient known to be MRSA positive? **YES** ☐ **NO** ☐ or to have any other HCAI e.g. C.Diff **YES** ☐ **NO** ☐ (List below)

If **YES**, please detail the date of last positive test, the site and any treatment: _____

Does Patient require Oxygen? **YES** ☐ **NO** ☐ IF YES, PLEASE SPECIFY FLOW RATE: _____

Additional Patient Information

Psychological Condition: Anxious ☐ Confused ☐ Depressed ☐ Diagnosed Mental Health condition ☐ _____
(Please state)

Insight into diagnosis/ prognosis: Patient _____

Carer _____

Sensory impairment – please detail: _____ dietetic requirements: _____

Mobility: _____ Bariatric requirements – please detail: _____

Any Aids & Adaptations in use? _____

Social Circumstances: *(e.g. Patient lives alone)* _____

Any other relevant information: _____

_____

Has Continuing Care been applied for: **YES** ☐ **NO** ☐ Date application submitted: _____

Please send any relevant documentation with this referral **i.e. OP/Discharge letters, a list of current medication and a photocopy of any Continuing Care Application. If patient lacks capacity, please ensure that the best interests documentation is included.**

Involvement of Other Agencies and Contact Details

District Nurse ☐ Name: _____ Tel. No.: _____

Specialist Palliative Care Nurse ☐ Name: _____ Tel. No.: _____

Social Worker ☐ Name: _____ Tel. No.: _____

Please identify any other Professional involved in patient's care:

Name: _____ Profession: _____ Tel. No.: _____

Name: _____ Profession: _____ Tel. No.: _____

General Practitioner Details

General Practitioner Name: _____ PCG/T No.: _____

Practice Address: _____ Post Code: _____

Tel. No.: _____ Fax No.: _____ Email: _____

Is this patient registered on the Gold Standards Framework Register? **YES** ☐ **NO** ☐

Does this patient have a Preferred Priorities for Care Document ? **YES** ☐ **NO** ☐

Please note: Referrals for INPATIENT admission can only be accepted if signed by a doctor or member of a Specialist Team. Day Therapy referrals may be signed for by any Health Care Professional. ALL referrals require patients medical lead to be informed

Referrers Signature: _____ Printed Name: _____

Designation: _____ Date: _____ Telephone: _____

Medical lead discussed and agreed with: **YES** ☐ **N/A** ☐