

PALLIATIVE CARE PARTNERSHIP Sussex Community NHS

REFERRAL FORM

Community Palliative Care Team

Hospice@Home Team
The Martlets Hospice

The Martlets Hospice Tel: 01273 964164
Wayfield Avenue
HOVE BN3 7LW
Fax: 01273 273450
SC-TR.PalliativeCare@nhs.net

In order to assist us to process this referral appropriately, please ensure this form is completed using the GSF Prognostic Indicators as guidance. www.qoldstandardsframework.nhs.uk

IS REFERRAL URGENT (advice/assessment within 2 working days)? Yes* \(\square \) No \(\square \) And/or contact by Hospice@Home team within 6 hours Yes* \(\square \) No \(\square \) *If yes please phone for immediate advice							
Patient Details / Label							
Surname		☐ Male/☐ Female A	ige:	Patient consent referral Yes ☐ No ☐			
First Name		Date of birth		Is GP aware of referral Yes ☐ No ☐			
Address		Marital Status		Office Use:			
		Ethnicity					
Postcode Tel		Mobile Tel					
NHS number Hosp		ital No. Religion					
Primary diagnosis(es) with date PPC if known:	_	There is a box overleaf to give details of ACPR in place? Yes/No	f diseas	se and treatment history)			
Next of Kin/Patient Representatives		Community Nurse Referral to community nursing team by referrer is also required		General Practitioner GP must be made aware of referral			
Name Address		Based at		Name Address			
Address		Telephone		Address			
Telephone		Fax					
Relationship to patient Existing care package details				Postcode			
Main Carer (if different from above) Name		Social Services Yes No Name		Telephone			
Telephone		Based at		Fax/email			
Relationship to patient		Tel Fax					
		Continuing care assessment completed: ☐Yes	□No				
Reason for Referral		Service requested		The patient is currently			
Complex pain/symptom control Complex social/psychological/spiritual		Home assessment by Palliative Care Team		At Home			
support Advance care planning		Out-patient assessment		Door nationt live slope? Ves C. Na C.			
'Hands on' Terminal care		Hospice@Home Assessment		Does patient live alone? Yes ☐ No ☐			
Benefits advice Other reason (please specify)		Respite					
Sale: reason (piease specify)		Patient's level of mobility/performance statu	us:				



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In-Patient details (if applicable)				
Hospital	Telephone			
Ward Direct Ward Ext.	Date of discharge (if known)			
Consultant 1 Direct tel:	Is Hospital Palliative Care team involved? Yes ☐ No ☐			
Consultant 2 Direct tel:	Is Macmillan site-specific CNS involved? Yes ☐ No ☐			
Brief history of diagnosis(es) and key trea	atments **NB please enclose copies of recent correspondence & results*	*		
Date Progression of disease and investigations/tro	eatment			
Current problems				
1.	4.			
2.	5.			
3.	6.			
Any other comments/information (including page 2)	sychosocial or spiritual issues and communication difficulties)			
Patient dum marie and a company				
Estimated prognosis: Less than 1 month 1-6	months 6-12 months More than 12 months			
Part Madical and Payabiatric History	Current Medication			
Past Medical and Psychiatric History				
	Known Drug			
	Sensitivities/Allergies: Yes □ No □			
	Details:			
Pacemaker/ICD? Yes □ No □				
Insight				
Has patient been told diagnosis? Yes No	Is patient aware of estimated prognosis? Yes \square No \square			
Does patient discuss the illness freely? Yes No No	Is carer aware of estimated prognosis? Yes No			
Please ensure patients are aware information will be held on computer according to the Data Protection Act.				
Referrer's Name (please print):	Referrer's signature :			
Job title:	Contact number: Bleep no:			
CD Current or Heavitals				
GP Surgery or Hospital:	Date:			