**REFERRAL FORM FOR ALL ORGANISATIONS**





**Fax to:**

**Hospice at Home Service, Wirral Hospice St John’s Referral Centre 0151 343 9589**

**E-mail to: Wih-tr.ReferralsWirralHospice@nhs.net**

**The contents of this fax/e-mail are strictly private and confidential. Should you receive this fax/email in error please contact the Sender to alert them and securely shred/destroy it immediately.**

**Please note:** in order to comply with our legal requirements this form

**must be destroyed** beyond redemption once your shift, relating to this referral has been completed. If you do not have access to a shredder, please forward this form in a sealed envelope as soon as possible to:

**Hospice at Home Team**

**Wirral Hospice St John’s**

**Mount Road**

**Higher Bebington, Wirral CH63 6JE**

Throughout the form items marked **\*** are mandatory fields therefore must be completed, also “Circle” replies for multiple choice ie Yes/No.

**\*Is the Patient aware of this referral? Yes / No**

**\*Is the Next of Kin aware of this referral? Yes / No**

Answering yes to any of these questions would indicate that you have gained consent.

If you have circled “No” in both instances, Wirral Hospice St John’s are unable to accept this referral until you are able to confirm the patient and/or the next of kin are aware.

PLEASE ENSURE THAT PRINT TEXT IS USED FOR LEGIBILITY

|  |
| --- |
| For hospice use only:Form faxed to MCRC once sit allocated to Marie Curie  |

|  |  |
| --- | --- |
| **Referrers full Name and contact Tel No’s \*** |  |
| **Referring Organisation Name (CCG etc) \*** |  |
| **Locality Code** **(if used) \*** |  |

|  |  |
| --- | --- |
| **Patients CCG \*** |  |
| **Service Name \*****e.g. planned or Multi Visit etc.** | **PLANNED** |

|  |  |
| --- | --- |
| **Is care being provided by any other agency?****(Please provide Details if Yes)** |  |

**\*\* Please note \*\***

**It is not within a Wirral Hospice St John’s Hospice at Home or Marie Curie Nurse’s role to attempt Cardio Pulmonary Resuscitation.**

**In the event of patient collapse, the Nurses will call an ambulance if, there is no indication in the patient’s notes, advising the patient resuscitation status.**

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient** **first name**\* |  | **Patient** **surname\*** |  |
| **Preferred name\*** |  | **Date of Birth\*** |  |
| **Gender\*** |  | **Language Preference** |  |
| **Ethnicity**\* |  |  |  |
| **Patients Address\******(where delivering care)*** |  **Post Code:**\* |
| **Contact Telephone No** \***(Please identify default)** | **HOME** | **NOK**  | **MOBILE**  |
| **Allow Calls to Patient?** | **Yes** |  **No** | **NHS Number\*** |
| **CHC Number:**\* | **CHI Number:\*** |
| **Preferred place of Care**\* |  | **Preferred place of Death**\* |  |
| **Any other salient details:****(Registered disabled etc.)** |
| **Are there Pets at the home? \****(If Yes - Provide details)* |
| **Are there Smokers in the Home? \****(If Yes – Provide further details)* |

**Patient Contacts**

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Full Name\*** |  | **GP Tel No:\****(Incl STD)* |  |
| **GP Code** \****(enter KN if not known)*** |  | **GP Surgery** *(If different to DN)* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **DN Full Name**\* |  | **Job Function**\* |  |
| **Surgery Address** |   **Post Code:**\* |
| **Telephone No’s***(identify default)* | **Primary No**\* | **Secondary No**  | **Mobile** |
| **Office** | **OOH No** \* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next of Kin OR****Main Carers Title**\* |  | **Preferred****Name** \* |  |
| **First Name** \* |  | **Surname** \* |  |
| **Next of Kin OR****Main Carers Address** |  **Post Code:** |
| **Relationship** |  | **Email address***(if applicable)* |  |
| **Contact Tel No.***(identify default)* | **Home** | **Work** | **Mobile** |

**Care Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Is there a Care Plan in the home?** \**(if not only an RN can be allocated***)** |  | **Is there a medication chart in the home?** \* |  |
| **Have all risk assessments been completed, including Manual Handling?**\**(Ensure supporting docs in home)* |  | **Is there Manual Handling Equipment in the home?** \**(list the items)* |  |
| **Is the Patients DNR status agreed?** \**(see page 1)* |  |  |  |
| **Priority of care needs**\* (Stable/Changing/Urgent) |  | **How many staff are required to safely move the patient?** \* |  |

**Diagnosis**

|  |  |
| --- | --- |
| **Primary diagnosis** \* |  |
| **Secondary diagnosis** |  |
| **Is the patient aware of diagnosis?** \* | **Yes** |  **No** | **Is the main carer aware of the diagnosis?** \* | **Yes** | **No** |
| **Prognosis** \* |  |
| **Is the patient aware of the prognosis?** \* | **Yes** | **No** | **Is the main carer****aware of the diagnosis?** \* | **Yes** | **No** |
| **Additional information****e.g. additional medical history** |  |

**Condition**

|  |  |  |
| --- | --- | --- |
| **Symptoms** \* **Pain** **Nausea** **Vomiting** **Breathlessness** **Depression** |  **Constipation** **Incontinent Bowels** **Incontinent Bladder** **Loss of Appetite** **Pressure Sore** |  **Alert** **Unconscious** **Confusion** **Agitation** **None Known** |
| **Does the Patient have difficulties with:-** **Hearing Eyesight Speech Coordination** |
| **Additional Nursing Information** **e.g. Mouth care, dressing, known infections, allergies.** |

**Environment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the patient live alone? \*** |  | **How will the nurse gain access? \*** |  |
| **Where can the nurse park?** **Any safety concerns with the area?** \* |  | **Any other safety concerns – e.g. history of falls**\* |  |
| **Any history of violence or aggression in the home?** \**(Please give details)* |  |

**Visit Pattern**

|  |  |  |  |
| --- | --- | --- | --- |
| **No. of days per week** \* |  | **Start Date** \* |  |
| **Preferred pattern- e.g.****Specifics (Mon/Wed) or flexible (Any)** \* |  | **End Date** \* |  |
| **Visit****Times** | **Night Sit** |  | **No of****Nurses** | **Night****Shift** |  |
| **Day Sit** |  | **Day****Shift** |  |
| **Mandatory Skill required** | *(e.g. Nippy machine, Bypap etc)* |
| **What are the arrangements for outside of office hour’s contact?** \* | *(we may need to advise you of patient update/changes)* |