**Wirral Specialist Palliative Care Referral Form**

Email completed form to **wchc.csps@nhs.net**V5 May 2025

**Please ensure you have made a referral to Community Nurses prior to completing referral to Wirral Community Specialist Palliative Care Team**

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| **Indicate** **service(s) required:** | **Hospice** **Services** | [ ]  Inpatient admission | [ ]  Wellbeing Services |  |
| [ ]  Outpatient Clinic | [ ]  MND Keyworker |  |
| **Wirral Community****Specialist** **Palliative Care Team** | [ ]  Community Specialist Nurse | [ ]  Occupational Therapist |  |
| [ ]  Physio | [ ]  Dietitian |  |
| Please Complete an EOL handover form if the patient is thought to be in last 12 months of life and send to email address on the separate EOL form  |
| **For urgent professional advice or urgent hospice inpatient unit admission,****Call 0151 343 9529 24 hours/365 days a year (#option 1 for professionals seeking advice).** |

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| Current Location of Patient: | [ ]  **Home** [ ]  **Care Home Name** [ ]  **Other Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**[ ]  **APH** [ ]  **Other Hospital Name Ward name/number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Patient Name**: |  | NHS No: |  | DOB: |  |
| Home Address: |  |
| Phone – Home: |  | Phone – Mobile: |  |
| Patient’s Email address |  | GP Surgery: |  |
| Patients Ethnicity: |  | Reasonable AdjustmentsIdentified Communication Needs | capacity/language/disability: |
| **Main Carer**/**Next of Kin**: |  | Relationship to patient: |  |
| Main Carer/Next of Kin Address: |  |
| Main Carer/Next of Kin – Preferred contact no |  | Main Carer/Next of Kin Email: |  |

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| **Phase of Illness: for info only** \*See bottom of Page 2 for explanations | [ ]  Stable [ ]  Unstable[ ]  Deteriorating [ ]  Dying | **Australian Karnofsky** **Performance Score %\*** | **for info only**  |
| **Main Diagnosis**  |  | **Date of Diagnosis:** |  |
| **PLEASE ATTACH ANY CLINC LETTERS/SCANS AND OTHER RELEVANT INFORMATION. PLEASE NOTE THIS FORM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.** |
| **Situation**Social e.g. living arrangements/POC Mobility |  |
| **Background**PMHPrognosisDiagnosis/Treatment journeyOther professionals involved |  |
| **Assessment**HopesGoalsPriorities of care |  |
| **Reason for referral** e.g. Complex pain symptom control/psychosocial  |  |
| **Known to other Specialist Support Teams and Other services Supporting the patient currently (specify any ongoing referrals to other****different services)** |
| Enter any other services supporting the patient here. |
| Patient’s awareness: | **Diagnosis** [ ]  **Yes** [ ]  **No** **Prognosis**  [ ]  **Yes** [ ]  **N**o **Consent to Referral**  [ ]  **Yes** [ ]  **No** |

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| **Advance Care Planning** – please give detail of any discussions that have already occurred and if any of the following are in place: *MCA Assessment / Best Interest Decision / DOLS / Existing LPA / ADRT / Advance Statement / DNACPR, Emergency Health Care Plan* | If **consent to referral is no** - please give details of best interest decision / discussion with relevant individuals: |
| Enter detail of any advance care planning discussions here. | Enter details of best interest decisions here. |
| **PPC/PPD discussed: Yes** [ ]  **No** [ ]   **Known PPC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Known PPD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  [ ]  SR1 (benefits) [ ]  DNACPR [ ]  EHCP [ ]  EOL Record of Care [ ]  EOL Register: **RED** [ ]   **AMBER** [ ]   **GREEN** [ ]   |

**This MUST be completed for all referrals. Form CANNOT be processed without this information.**

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| **Item** |  **NO** |  **YES** |  **Details** |
| Known allergies | [ ]  | [ ]  |  |
| Indwelling Intravenous line in situ (e.g. PICC / Hickman etc.) | [ ]  | [ ]  |  |
| Syringe Driver in situ? | [ ]  | [ ]  |  |
| Currently receiving IV antibiotics / fluids or other intravenous therapy | [ ]  | [ ]  |  |
| Requires O2 | [ ]  | [ ]  |  |
| Patient agitated or confused | [ ]  | [ ]  |  |
| Indwelling drains in situ (e.g. nephrostomy, ascetic drain, chest drain, other drains) | [ ]  | [ ]  |  |
| History of MRSA / C.Difficile / other infection | [ ]  | [ ]  |  |
| Current diarrhoea | [ ]  | [ ]  |  |
| Diabetes requiring insulin therapy | [ ]  | [ ]  |  |
| Receiving NG, PEG or TPN feeding | [ ]  | [ ]  |  |
| Recent chemotherapy (within 3 weeks) | [ ]  | [ ]  |  |
| Pressure sores or wounds (please provide information on category and sites) | [ ]  | [ ]  |  |
| Specific dietary requirements | [ ]  | [ ]  |  |
| Is a Care Package in situ? | [ ]  | [ ]  |  |
| Non-Invasive Ventilation | [ ]  | [ ]  |  |
| ICD / Pacemaker  | [ ]  | [ ]  | Has it been deactivated[ ]  No [ ] Yes  |
| Falls History – has the patient had any falls in the last 12 weeks) | [ ]  | [ ]  |  |
| Height & Weight likely to require specialist equipment or care | [ ]  | [ ]  |  |

**Please complete all fields below, form cannot be processed without this information.**

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| **Form Completed By:** | **Job Title:** |
|  |  |
| **Location:** | **Contact Telephone No:** |
|  |  |
| **Signed:** | **Date:** |
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**\*Phase of Illness explanation**

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|  | **This is the current phase if…** | **This phase ends when…** |
| **Stable** | Patient’s problems and symptoms are adequately controlled by established plan of care **and** further interventions to maintain symptom control and quality of life have been planned **and** family / carer situation is relatively stable and no new issues are apparent.  | The needs of the patient and of family / carer increase, requiring changes to the existing plan of care. |
| **Unstable** | An urgent change in the plan of care or emergency treatment is required **because** the patient experiences a new problem that was not anticipated in the existing plan of care **and / or** the patient experiences a rapid increase in the severity of a current problem **and / or** family’s / carer’s circumstances change suddenly impacting on patient care.  | The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom / crisis has fully resolved but there is a clear diagnosis and plan of care (i.e, patient is stable or deteriorating) **and / or** death is likely within days (i.e. patient is now dying). |
| **Deteriorating** | The care plan is addressing anticipated needs, but requires periodic review**, because** the patient’s overall functional status is declining **and** the patient experiences a gradual worsening of existing problem(s) **and / or** the patient experiences a new, but anticipated, problem **and / or** the family / carer experience gradual worsening distress that impacts on the patient care.  | Patient condition plateaus (i.e, patient is now stable) **or** an urgent change in the care plan or emergency treatment **and / or** family / carers experience a sudden change in their situation that impacts on patient care, and urgent intervention is required (i.e. patient is now unstable) **or** death is likely within days (i.e. patient is now dying) |
| **Dying**  | Dying: death is likely within days. | Patient dies **or** patient condition changes and death is no longer likely within days (i.e, patient is now stable or deteriorating).  |
| **Australian Karnofsky Performance Scale**  |
| **100%**  | Normal, no complaints or evidence of disease. | **50%** | Considerable assistance and frequent medical or nursing care required. |
| **90%** | Able to carry on normal activity, minor signs or symptoms of disease. | **40%**  | In bed more than 50% of the time. |
| **80%** | Normal activity with effort, some signs or symptoms of disease. | **30%** | Almost completely bedfast. |
| **70%** | Cares for self, but unable to carry on normal activity or do active work. | **20%** | Totally bedfast and requiring extensive nursing care by professionals and/or family. |
| **60%** | Able to care for most needs but requires occasional assistance. | **10%** | Comatose or barely rousable, unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly. |