**Wirral Specialist Palliative Care Referral Form**

Email completed form to [**wchc.csps@nhs.net**](mailto: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 Adjustments  Identified 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**  PMH  Prognosis  Diagnosis/Treatment journey  Other professionals involved | |  | | |
| **Assessment**  Hopes  Goals  Priorities 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.**

|  |  |
| --- | --- |
| **Form Completed By:** | **Job Title:** |
|  |  |
| **Location:** | **Contact Telephone No:** |
|  |  |
| **Signed:** | **Date:** |
|  |  |

**\*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. |