**Specialist Palliative Care Community Teams & Inpatient Units across South & West London**

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| **Greenwich & Bexley Community Hospice**  Bostall Hill, Abbey Wood **SE2 0GB**  Assessment Coordination Team  Tel: 020 8320 5837  **Email:** [**gbch.referrals@nhs.net**](mailto:gbch.referrals@nhs.net) | **Meadow House Hospice**  Southall **UB1 3HW**  Tel: 020 8967 5179  Fax 020 8967 5756  **Email:** [**referralsmeadowhouse@nhs.net**](mailto:referralsmeadowhouse@nhs.net) | **St John’s Hospice**  Grove End Road, St John’s Wood  **NW8 9NH**  Tel: 020 7806 4040  Fax: 020 7806 4041  **Email:** [**Clccg.stjohnsreferrals@nhs.net**](mailto:Clccg.stjohnsreferrals@nhs.net) |
| **Guy’s & St Thomas’**  **Community Team:**  Guy’s Hospital, Great Maze Pond  **SE1 9RT**  Tel: 020 7188 4754 Fax: 020 7188 4748  **Email:** [**gst-tr.gstt-palliativecare@nhs.net**](mailto:gst-tr.gstt-palliativecare@nhs.net) | **Michael Sobell Hospice**  (Harlington Hospice) Northwood, Middlesex **HA6 2RN**  Tel: 020 3824 1268  **Email:** [**Hillccg.MSHreferrals@nhs.net**](mailto:Hillccg.MSHreferrals@nhs.net) | **St Luke’s Hospice**  Kenton Road, Harrow **HA3 0YG**  Tel: 020 8382 8000 Fax: 020 8382 8080  Community Team Fax: 020 8382 8092  Referrals mob: 07593 135303  **Email:** [**LNWH-tr.referralsstlukes@nhs.net**](mailto:LNWH-tr.referralsstlukes@nhs.net) |
| **Harlington Hospice**  St Peter’s Way, Harlington **UB3 5AB**  Tel: 020 8759 0453 Fax: 020 8759 0600  **Email:** [**HILLCCG.harlingtonhospicereferrals@nhs.net**](mailto:HILLCCG.harlingtonhospicereferrals@nhs.net) | **Pembridge Hospice**  St Charles Centre for Health & Wellbeing, Exmoor Street, **W10 6DZ**  Tel: 020 8102 5000  **Referrals to go to CLCH SPA:**  [**clcht.spa.referral@nhs.net**](mailto:clcht.spa.referral@nhs.net)  E-Fax:030 00083251 Tel: 020 8102 5520 | **St Raphael’s Hospice**  London Road, North Cheam **SM3 9DX**  Tel: 020 8099 7777 Fax: 020 8099 1724  **Sutton CCG referrals to go to:** [**sutccg.raphaelshospicereferrals@nhs.net**](mailto:sutccg.raphaelshospicereferrals@nhs.net)  **Merton CCG referrals to go to:** [**merccg.raphaelshospicereferrals@nhs.net**](mailto:merccg.raphaelshospicereferrals@nhs.net) |
| **Harrow Community Team**  Kenton Road, Harrow **HA3 0YG**  Tel: 020 8382 8084  Fax: 020 8382 8085  **Email:** [**LNWH-tr.HarrowcommunitySPCT@nhs.net**](mailto:LNWH-tr.HarrowcommunitySPCT@nhs.net) | **Princess Alice Hospice** West End Lane, EsherKT10 8NA Tel: 0300 10 20 100  Fax: 01372 470937  **Email:** [**SDCCG.clinicaladminpah@nhs.net**](mailto:SDCCG.clinicaladminpah@nhs.net) | **Royal Trinity Hospice**  Clapham Common **SW4 0RN**  Tel: 020 7787 1000  Ref & Admissions Nurse: 020 77871065  Fax: 020 7787 1067  **Email:** **rth.referrals@nhs.net** |
| **Hillingdon Community**  **Palliative Care Team**  Pield Heath Road, Uxbridge  **UB8 3NN**  Tel: 01895 485235  **Email:** [**cnw-tr.hchcontactcentrerefs@nhs.net**](mailto:cnw-tr.hchcontactcentrerefs@nhs.net) | **St Christopher’s Hospice**  Lawrie Park Rd, London **SE26 6DZ**  Referral & Admissions  Tel. 020 87684582  **Email:** [**st.christophers@nhs.net**](mailto:st.christophers@nhs.net) |  |

For further information and advice on these services, please visit the Hospice UK service directory at: <http://www.hospiceuk.org/about-hospice-care/find-a-hospice> and enter the postcode provided above.

Every hospital has a Specialist Palliative Care team;   
if your patient is a *hospital inpatient,* please contact the team, via the relevant hospital switchboard.

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| **FAX MESSAGE** | | |
| **From:** | **To:** | |
| **Fax No:** | **Date:** | |
| **No. of pages** (incl. cover sheet): |  | |
| **Additional information** | | |
| **Confidentiality:** The content of this fax and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above. | | |
| **PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM  – including recent clinic letters, blood tests and most recent imaging.**  **NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT** | | |
| **PATIENT NAME** | | **NHS No.** |

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| Essential Patient Details | | | | | |
| Surname | | Male | Female | | Patient consent to palliative care involvement?  Yes  No  Best interest |
| First Name | | DoB | Age: | | Is GP aware of referral?  Yes  No |
| Address | | | | | |
| Postcode | Marital Status | | | Ethnicity | |
| Tel. | Mob. | | | | |
| NHS number | **Hospital No.** | | | | |

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| Primary diagnosis(es) |

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| Communication | Other barriers to communication/registered disabilities: |
| Fluent in English? Yes  No  (If ‘no’ proceed with remaining questions) |
| First Language, if not English: |
| Would interpreter be helpful to patient and Palliative Care staff? Yes  No |

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| --- | --- | --- | --- | --- | --- | --- |
| Next of Kin/Patient Representatives | District Nurse Yes  No | | | | General Practitioner | |
| Name | Name | | | | Name | |
| Address | Based at | | | | Address | |
| Postcode | Telephone | | | |  | |
| Telephone | Fax | | | |  | |
| Relationship to patient |  | | | | Postcode | |
| Main Carer (if different from above) | Social Services Yes  No | | | | Telephone | |
| Name | Name | | | | Fax/Email | |
| Telephone | Based at | | | | CCG: | |
| Relationship to patient | Tel | Fax | | |  | |
| **Continuing care assessment completed:**  Yes  No | | | |
| **Continuing care funding agreed:**  Yes  No | | | |
| Reason for Referral | Service requested | | | | The patient is currently | |
| Pain/symptom control ……………………..…….  Emotional/psychological support ………..…  Social/financial ……………………………..….……  Assessment for hospice admission……..…..  Carer support ..……..………………………….…...  Other reason (please give details below). | Home assessment and support. ………..………...  Hospital assessment ….....................................  Day Care …………………………..……….…………...…...  Outpatient service …………………….….….………….  Admission (*delete*). ……………………….…………..…  Respite / symptom control / terminal care  Hospice at Home ………………………………………... | | | | At Home ………………………...……………………..  In Hospital (see over) …………………………..…  Other e.g. Nursing Home ..……………..…..….  Please specify | |
| Does patient live alone? Yes  No | |
| Any access issues (e.g. key safe): | | | | | | |
| **MRSA Status**  Positive  Negative  Not known | | | | **Any other communicable infection:** | | |
| **Special device in situ?** Yes  No  If yes, give details (e.g. trache / PEG / ICD / NIPPV): | | | | | | |
| Referrer’s Name: | | | Contact number: | | | Bleep no: |
| Hospital/Surgery: | | | **This information required on both pages if faxing** | | | |

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| **IS REFERRAL URGENT (assess within 2 working days)? Yes  No** |
| **IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE** |

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| In-Patient details | | Patient Name: |
| Hospital | | NHS No: |
| Ward | Direct Ward Ext. | Telephone |
| Key worker | | Date of discharge (if known) |
| Consultant | | Is Palliative Care team involved? Yes  No |

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| Brief History of diagnosis(es) and Key treatments | | |
| Date | Progression of disease and investigations/treatment | Consultant and hospital |
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| Current palliative care problems | | | | | | |
| 1. | | | | 4. | | |
| 2. | | | | 5. | | |
| 3. | | | | 6. | | |
| **Patient Mobility:** | | | | **Bariatric Nursing required?** Yes  No | | |
| **Any other comments/information** (including preferences expressed about care, other psychosocial or spiritual issues or DOLS) | | | | | | |
|  | | | | | | |
| **Referrer’s expectation of current treatment** symptom control  / life prolonging  / curative | | | | | | |
| **Prognosis:** In your opinion, is the patient | | | | | | |
| **Stable?**  Yes  No | **Unstable?** Yes  No | | **Deteriorating?** Yes  No | | | **Dying?** Yes  No |
| Is death anticipated within: | Months | | Weeks | | | Days |
| **Patient on Coordinate My Care?** Yes  No  Unknown  If not, please give reason | | | | | | |
| **On the GSF register?** Yes  No  Unknown | | | **DNACPR in place?** Yes  No | | | |
| Past Medical and Psychiatric History | | **Current Medication** | | |  | |
|  | | |  | |
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|  | |  | | | **Known Drug Sensitivities/Allergies:**  Yes  No | |
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|  | |  | | | **Details:** | |
|  | |  | | |  | |
|  | |  | | |  | |
| **Insight:** **Has patient been told diagnosis?** Yes  No | | | **Is the carer aware of patient’s diagnosis?** Yes  No | | | |
| **Does patient discuss the illness freely** Yes  No | | |  | | | |

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| Please ensure patients are aware information will be held on computer according to the Data Protection Act. | | |
| Referrer’s signature: | Name: | |
| Job title: | Contact number: | Bleep no: |
| Surgery or Hospital: | Date: | |