**Specialist Palliative Care Community Teams & Inpatient Units across NC & NE London**

|  |  |  |
| --- | --- | --- |
| **Islington ELiPSe** [ ] **Community Palliative Care Team** St. Pancras Hospital, 5th Floor South Wing, 4 St Pancras Way, London **NW1 0PE**Tel: 020 3317 5777**Email:** palliative.islington@nhs.net | **Saint Clare Hospice:** [ ]  Hastingwood Rd, Hastingwood, Harlow **CM17 9JX** Tel: 01279 773700 **Email:** SCLHO.referrals@nhs.net | **South Camden Palliative Care** [ ] **Team** St. Pancras Hospital, 5th Floor South Wing, 4 St Pancras Way, London **NW1 0PE** Tel: 020 3317 5777**Email:** Palliative.southcamden@nhs.net |
| **Marie Curie Hospice** [ ] **Hampstead:** 11 Lyndhurst Gardens **NW3 5NS**Tel: 020 7853 3400**Email for inpatient unit & day therapy:** InpatientUnit.HampsteadHospice@nhs.netdaytherapyunit.hampsteadhospice@nhs.net | **Saint Francis Hospice** [ ] Broxhill Road, Havering-Atte-Bower,Romford **RM4 1QH** Tel: 01708 758606 **Email:** NELCSU.saintfrancishospicereferrals@nhs.net | **The Margaret Centre** [ ] Whipps Cross Hospital, Whipps Cross Rd, Leytonstone E11 1NR Tel: 020 8535 6605 **Email:** BHNT.margaretcentrereferrals@nhs.net |
| **North London Hospice** [ ] 47 Woodside Avenue **N12 8TT**Tel: 020 8343 8841**Email:** **Northlondonhospice.firstcontact@nhs.net** | **Saint John’s Hospice** [ ] Grove End Road, St John’s Wood **NW8 9NH** Tel: 020 7806 4040 **Email:** Clccg.stjohnsreferrals@nhs.net | **The Royal Free Palliative Care Team** [ ] Royal Free Hospital, Pond Street, London **NW3 2QG** Tel: 020 78302905**Email:** rf.palliativecare@nhs.ne**t** |
| **Redbridge Community Palliative** [ ] Care TeamHainault Health Centre, Manford Way, Chigwell, IG7 4DF Tel: 0300 300 1901 Fax: 020 8430 8466**Email:** Nem-tr.Redbridgespecialistpalliativecareteam@nhs.net | **Saint Joseph’s Hospice** [ ] Mare Street, Hackney **E8 4SA**Tel: 0300 30 30 400**Email:** stjosephs.firstcontact@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.

|  |
| --- |
| **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.**       |

|  |
| --- |
| 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.**       |

|  |
| --- |
| Primary diagnosis(es)      |

|  |  |
| --- | --- |
| 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 [ ]  |

|  |  |  |
| --- | --- | --- |
| 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** |

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

|  |  |
| --- | --- |
| 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 [ ]  |

|  |
| --- |
| Brief History of diagnosis(es) and Key treatments |
| Date | Progression of disease and investigations/treatment | Consultant and hospital |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

|  |
| --- |
| 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 or** **Health Analytics ?** 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** |       |
|       |       |
|       |       |       |
|       |       |       |
|       |       | **Known Drug Sensitivities/Allergies:** Yes [ ]  No [ ]  |
|       |       |
|       |       | **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 [ ]  |  |

|  |
| --- |
| 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:       |