Specialist Palliative Care (SPC) Community and SPC Inpatient Unit Referral Form

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.net daytherapyunit.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.net
Redbridge Community Palliative Care Team ☐ Hainault 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**	

Referral Form for SPC Community and Inpatient Units

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 ..... ☐	Home assessment and support. ..... ☐	At Home ..... ☐
Emotional/psychological support ..... ☐	Hospital assessment ..... ☐	In Hospital (see over) ..... ☐
Social/financial ..... ☐	Day Care ..... ☐	Other e.g. Nursing Home ..... ☐
Assessment for hospice admission..... ☐	Outpatient service ..... ☐	Please specify
Carer support ..... ☐	Admission (*delete*). ..... ☐	Does patient live alone? Yes ☐ No ☐
Other reason (please give details below). ☐	Respite / symptom control / terminal care	
	Hospice at Home ..... ☐	

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 ☐

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:

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Surgery or Hospital:	Date: