**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 TeamTel: 020 8320 5837 **Email:** **gbch.referrals@nhs.net** | **Meadow House Hospice** [ ] Southall **UB1 3HW**Tel: 020 8967 5179 Fax 020 8967 5756**Email:** **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** |
| **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** | **Michael Sobell Hospice** [ ] (Harlington Hospice)Northwood, Middlesex **HA6 2RN**Tel: 020 3824 1268**Email:** **Hillccg.MSHreferrals@nhs.net** | **St Luke’s Hospice** [ ] Kenton Road, Harrow **HA3 0YG**Tel: 020 8382 8000 Fax: 020 8382 8080Community Team Fax: 020 8382 8092Referrals mob: 07593 135303**Email:** **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** | **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**E-Fax:030 00083251 Tel: 020 8102 5520 | **St Raphael’s Hospice** [ ] London Road, North Cheam **SM3 9DX**Tel: 020 8099 7777**Referrals email** : srh.referrals@nhs.net |
| **Harrow Community Team** [ ] Kenton Road, Harrow **HA3 0YG**Tel: 020 8382 8084 Fax: 020 8382 8085**Email:** **LNWH-tr.HarrowcommunitySPCT@nhs.net** | **Princess Alice Hospice** [ ] West End Lane, Esher KT10 8NATel: 0300 10 20 100Fax: 01372 470937**Email:** **SDCCG.clinicaladminpah@nhs.net** | **Royal Trinity Hospice** [ ] Clapham Common **SW4 0RN**Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065Fax: 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** | **St Christopher’s Hospice** [ ] Lawrie Park Rd, London **SE26 6DZ**Referral & AdmissionsTel. 020 87684582 **Email:** **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** |       |
|       |       |
|       |       |       |
|       |       |       |
|       |       | **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 [ ]  |  |

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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:       |