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

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

Greenwich & Bexley Community Hospice ☐ Bostall Hill, Abbey Wood **SE2 0GB** Assessment Coordination Team Tel: 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 8080 Community Team Fax: 020 8382 8092 Referrals 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 8NA** Tel: 0300 10 20 100 Fax: 01372 470937 **Email:** 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	**St Christopher's Hospice** ☐ Lawrie Park Rd, London **SE26 6DZ** Referral & Admissions Tel. 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.

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.	

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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 ..... ☐	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):	

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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

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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? 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:

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Job title:	Contact number:	Bleep no:
Surgery or Hospital:	Date:	