Palliative Care Register and Care at Home Referral Form - Part 1 (Mandatory)

Consent and knowledge			
	Diagnosis	**Prognosis**	**Referral***
Is the patient* aware of?			
Is the relative aware of?			

PLEASE NOTE PATIENT MUST BE AWARE OF AND CONSENTING TO REFERRAL BEFORE PROCEEDING UNLESS THEY LACK CAPCACITY AND REFERRAL IS BEING MADE IN PATIENTS BEST INTERESTS

Patient Details			
Name		**Date of Birth**	
NHS Number		**Current Location**	
Home Address		**Discharge address (if different from Home address)**	
Home Contact No		**Discharge Address Contact No**	
GP Name		**GP Address**	
Next of Kin Name		**Next of Kin contact No**	
Date of discharge;		**CCG:**	

Clinical Details	
Confirmed Diagnosis of Life limiting illness	

Phase of illness	**Stable/Unstable/Deteriorating/Dying**		
Prognosis			
Any metastasis?			
RNT Level		**RNT Score**	
What is the patient's resuscitation status at time of referral?			

Reason for requesting referral?

	Yes	No
Are there any other health conditions?		
Are there any known infections?		
Does the patient have a ReSPECT Form?		
Has the patient got a signed ADRT?		
Are there any communication problems?		
Have there been any concerns regarding decision making?		
Is there any challenging behaviour?		
Does the patient have continence issues?		
Has an advanced care plan been completed?		
Does the patient have complex needs, psychological or symptomatic?		
Is the patient or any member of the household suspected or confirmed to have COVID19?		
Does the patient have anticipatory medication in the home?		

If you answered yes to any of the above questions, please give further details here

	Yes	No
Is the patient mobile?		

Does the patient live alone?		

Referrer Details			
Date of Referral		**Time of Referral**	
Name		**Job Title**	
Job Title		**Contact number**	

Please tick which organisations you would like you referral sent to			
Community Nursing		**Community Hospice Team**	
Macmillan		**Marie Curie**	

Please note:- If GP referring please ensure a share of patient records has been actioned.

Is this referral for a package of care and/or nights? If **Yes** please complete **Section 2.**

Is this referral for physio and OT? If **Yes** please complete **Section 2.**

Part 2 – Packages of care/Nights/Physio/OT support only

Brief reason for request for emergency funding

Care Requested	**Needs Assistance**	**Needs Full Care**	**Independent**	**Details must be given for ALL areas where care is required**
All aspects of personal care				
Breathing				
Nutrition				
Continence				

Care Requested	Needs Assistance	Needs Full Care	Independent	Details must be given for ALL areas where care is required
Skin				
Mobility Please include if hoist is required				
Communication				
Psychological & Emotional				
Cognition				
Behaviour				
Drug Therapies & Medication				
Altered States of Consciousness				

Current nursing home or care agency details (if applicable)
Private Carers ☐ **Agency care package** ☐ Please give number of hours provided in current package:

CARE AGENCY PACKAGE	No. of Hrs and Arrival Time per visit Each box completed must show both length of call and number of carers required						
Tick days care required	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Am							
Lunch							
Tea							
Bed							
Waking Night							
Sleeping Night							

Total Hours							

Specific Requirements:	**Yes**	**No**	**Details must be given for ALL applicable fields**
Female carer accepted	☐	☐	
Male carer accepted	☐	☐	
Keycode / Assisted Technology?	☐	☐	**Do not include key code number**
Will family / friend let the carer in?	☐	☐	
Are there any pets?	☐	☐	
Does anybody in the household smoke?	☐	☐	
Is Life Line available?	☐	☐	
What facilities are available to carer? (ie place to rest, kitchen , toilet, phone)	☐	☐	
Specific directions or parking details?	☐	☐	
Other	☐	☐	

- **Please email completed form to:**

  necmid.pcccreferrals@nhs.net