

**Living Well Centre at St Cuthbert’s Hospice**

Outpatient Services for those with Specialist Palliative Care Needs

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| Title: | Surname: | | | | Forenames: | | Known as: |
| D.O.B: | | Age: | Sex:  M / F | NHS No: | | Date of Referral: | |

**Please ensure that this form is fully completed, or it may be rejected and returned to the referrer for completion**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Address:  Postcode: | | | Referral:  Standard Urgent | |
| Referred By:  Designation:  Contact: | |
| Telephone No: | | Lives Alone:  Yes / No |
| Ethnic Group:  Interpreter Required: Yes / No | | Religion: | GP:  Address:  Tel No: | |
| Diagnosis/Date: | | |
| Is patient aware of diagnosis  Yes / No | Is carer aware of diagnosis  Yes / No | | Macmillan Nurse Involved? | Tel No: |
| Carer/NOK and relationship:  Address:  Tel No: | | | District Nurse: | Tel No: |
| Clinical Nurse Specialist: | Tel No: |
| Informed consent obtained to referral with:  Patient NOK/carer  Health or Social care professionals consulted/notified regarding the referral:  GP District Nurse Macmillan Nurse Consultant Specialist Nurse  Other …………………………………………………………………………………… | | | Consultant:  Previous or present occupation: | Tel No: |



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| **Reason for referral:** | **Additional support required:** | |
| **Symptom Management** | **Nursing Support** | **Blood Transfusion** |
| **Emotional Support** | **Breathlessness Management** | **Fatigue Management** |
| **Palliative Rehabilitation** | **Occupational Therapy** | **Physiotherapy** |
| **Dementia Support** | **Cognitive Stimulation Therapy** | **Admiral Nurse** |
| **Other** | **Acupuncture (Physio)** | **Carer Support (Social Worker)** |

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| **Risks**  Is there a risk of physical/verbal aggression? Yes 🞎 No 🞎  Is there a history of alcohol or drug dependency? Yes 🞎 No 🞎  Relevant mental health issues? Yes 🞎 No 🞎  If yes to any of the above, or any other known risks please comment below: | **Advanced decisions/statements**  EHCP:  Discussed: Yes 🞎 No 🞎  Completed: Yes 🞎 No 🞎  LPA:  Discussed: Yes 🞎 No 🞎  Completed: Yes 🞎 No 🞎  DNACPR:  Discussed: Yes 🞎 No 🞎  Completed: Yes 🞎 No 🞎  Any other advanced decisions/statements completed or discussed: |
| **Preferred place of care:** | **Preferred place of death:** |



|  |  |
| --- | --- |
| Relevant medical history including medication, allergies and any current nursing interventions: | Social History: |
| Please include any other relevant information relating to this referral:  Any PMH of cognitive impairment (please state if any recent assessments complete) | |
| Additional information:  Oxygen therapy 🞎 Syringe Driver 🞎 Wounds/pressure damage 🞎 Known infection 🞎  If yes to any of the above, or any other relevant information please comment below: | |

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Referral completed by:

Designation:

Date:

Please return this referral form by email to:

[NECNE.StCuthbertsHospiceReferrals@nhs.net](mailto:NECNE.StCuthbertsHospiceReferrals@nhs.net)

**Living Well Centre**

St Cuthbert’s Hospice

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