

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

Outpatient Services for those with Specialist Palliative Care Needs

|  |  |  |  |
| --- | --- | --- | --- |
| 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 diagnosisYes / No  | Is carer aware of diagnosisYes / 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: |



|  |  |
| --- | --- |
| **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)** |

|  |  |
| --- | --- |
| **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: |

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

Referral completed by:

Designation:

Date:

Please return this referral form by email to:

NECNE.StCuthbertsHospiceReferrals@nhs.net

**Living Well Centre**

St Cuthbert’s Hospice

Park House Road

Durham

DH1 3QF

Tel: 0191 386 1170