**Specialist Palliative Care Referral Form - County Durham and Darlington**

Is Referral Urgent? (Assessment needed within 24 hours) Yes  No

If yes, please also telephone the service provider to discuss

If there are particular requirements (e.g. isolation for infection, bariatric bed) please ensure this is clearly indicated and discussed with the service provider

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| Please send this referral individually to each of the requested services | |
| Alice House Hospice, Hartlepool  01429 855555 [alicehousehospice.referrals@nhs.net](mailto:alicehousehospice.referrals@nhs.net) | **Inpatient:**  End of Life Care  Symptom Management  Crisis Intervention  Other (please specify) |
| **Day Services:**  Day hospice service  Family Support  Other (please specify) |
| Community Specialist Palliative Care Team  03000 267979  [cddft.specialistpalliativeteam@nhs.net](mailto:cddft.specialistpalliativeteam@nhs.net) | **Community Services:**  Complex end of life care needs (e.g. family, physical, psychological)  Uncontrolled complex symptoms  Other (please specify) |
| St Cuthbert’s Hospice, Durham  0191 3861170  [NECNE.StCuthbertsHospiceReferrals@nhs.net](mailto:NECNE.StCuthbertsHospiceReferrals@nhs.net) | **Inpatient:**  End of Life Care  Symptom Management  Crisis Intervention  Other (please specify) |
| **Day Services:**  Living Well Centre  Psychological / Emotional Support  Family Support  Other (please specify)  **Day Treatment:**  Blood transfusion  Bisphosphonate infusion |
| St Teresa’s Hospice, Darlington  01325 254321  [care.darlington.stteresashospice8hx98@nhs.net](mailto:care.darlington.stteresashospice8hx98@nhs.net) | **Inpatient:**  End of Life Care  Symptom Management  Crisis Intervention  Other (please specify) |
| **Community Hospice Services:**  Hospice at Home (CHC)  Volunteer Visitor |
| **Day Services:**  Family Support (social work/counselling)  Bereavement Care  Wellbeing Hub  Lymphoedema  Complementary therapies (acupuncture/massage) |
| Willow Burn Hospice, Lanchester  01207 529224  [willowburnhospice.referrals@nhs.net](mailto:willowburnhospice.referrals@nhs.net) | **Inpatient:**  End of Life Care  Symptom Management  Crisis Intervention  Other (please specify) |
| **Day Services:**  Day hospice service  Family Support  Other (please specify) |

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| Referrer’s Details | | |
| Referrer’s name: | Contact number: | |
| Job title: | Contact email: | |
| Referring Organisation: | | Date of referral: |

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| Patient’s Details | | | |
| Forename: | Surname: | DOB: | Age: |
| NHS no: | Gender: Male  Female  Other | | |
| Ethnicity: | Religion: | First language, if not English: | |
| Address: | | | Postcode: |
| Current location if not home address: | | | |
| Phone: | | | |
| GP Surgery: | | | |
| GP Phone number: | | | |

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| Next of Kin Details | | |
| Name: | Relationship to patient: | Phone: |
| Address (if different to patient): | | |

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| Reason for Referral | | |
| Reason for referral / concerning symptoms: | | |
| Primary Diagnosis and key treatments: | | |
| Other significant past medical and psychiatric history: | | |
| Current Medications / Allergies: | | |
| Other specific requirements (e.g. current infection status, bariatric, amputation, pressure damage, significant falls risk): | | |
| DNACPR in place: Yes  No | EHCP: Yes  No | LPA: Health and Welfare: Yes  No  Property and Finance: Yes  No  Details: |
| Other documents in place (e.g. court of protection order, ADRT): | | |
| Is patient aware of referral? Yes  No  If no, please give details: | | NOK aware of referral? Yes  No  If no, please give details: |
| Does patient have capacity at present to make decision around referral? Yes  No  If no, is MCA documentation/DOLS in place? | | |
| Other equipment in use (e.g. syringe driver, PEG, ICD, NG tube, tracheostomy, pacemaker): | | |
| Oxygen requirement? Yes  No  If yes, nasal  mask  Amount: L/min  Willow Burn Hospice referrals - please arrange delivery of oxygen concentrator for patient’s arrival, once referral has been accepted. | | |
| Family dynamics to be aware of? Yes  No  If yes, please give details: | | |
| Any safeguarding concerns? Yes  No  If yes, please give details: | | |
| Any risks that community / home visiting staff need to be aware of? Yes  No  If yes, please specify (e.g. alcohol/drug misuse in household, pets at home, history of physical/verbal aggression) | | |