**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, Hartlepool01429 855555 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 Team03000 267979cddft.specialistpalliativeteam@nhs.net | **Community Services:**Complex end of life care needs (e.g. family, physical, psychological) [x]  Uncontrolled complex symptoms [ ]  Other (please specify) [x]  |
| St Cuthbert’s Hospice, Durham0191 3861170NECNE.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, Darlington01325 254321care.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, Lanchester01207 529224willowburnhospice.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: Dr Annabelle Plyming | Contact number: 0191 333 2338 |
| Job title: Consultant in Palliative Medicine | Contact email: annabelleplyming@nhs.net  |
| Referring Organisation: UHND | 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): |

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| Additional information |
| 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?  |
| Has the patient agreed to share information from the referrer to the electronic patient record? Yes [ ]  No [ ]  Not asked [ ] Has the patient agreed to share information from the specialist unit to the electronic patient record? Yes [ ]  No [ ]  Not asked [ ]  |
| Other equipment in use (e.g. syringe driver, PEG, ICD, NG tube, tracheostomy, pacemaker): |
| Oxygen requirement? Yes [ ]  No [ ]  If yes, nasal [ ]  mask [ ]  Amount: L/minWillow 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) |