**Referral Guidance for St Nicholas Hospice Care’s Community Clinical Teams**

***Aim***

We aim to support individuals, their families/carers and health and social care professionals in managing specialist/complex symptoms that have not responded to first or second-line treatments in their own homes/usual place of residence.

***Current services offered***

* General telephone advice and support to health care professionals (We **DO NOT** need a referral to give advice).
* Formal and informal education to other health care professionals.
* Informal education/coaching to individuals, their families and carers, equipping them with the skills required to provide good end-of-life care.
* Collaborative working with other health and care professionals from across the system.
* Complex advice on advanced care planning and decisions to refuse treatment – completion of My Care Wishes.
* Complex symptom management support for patients that have tried first and second-line treatments without success.
* Signposting to other local and national services as required through linking with locality Integrated Neighbourhood Team co-ordinator.
* Complex psychological support caused by current illness and/or bereavement.

***Things to consider before making a referral***

Most individuals**, IF** referred to us due to their **complex** and **specialist** palliative care needs, are likely to have other agencies from across the system already involved on a regular basis. Therefore, please think of the following prior to making a referral:

* If the individual is not already known to the District Nursing Team, please make a referral to them.
* If the patient does not have specialist palliative care needs, please consider referring to more generalist services.
* Is the reason for considering a referral something the patient’s own GP could deal with?
* If a patient is being discharged to their own home/usual place of residence, e.g. care home, are end-of-life, but without specialist needs, we **DO NOT** require a referral and can give advice as and when required.
* Is this issue a social/personal care issue? If so, please refer to social services / Continuing Healthcare Team. (Social services Customer First on 0808 800 4005 and Continuing Health Care on 01473 770198).
* Is this individual in a hospital? If so, please ring us to discuss and refer a few days prior to discharge.
* We are currently mainly operating a consultative service and trying to reduce our face-to-face contacts (due to COVID-19), so advice may be given virtually by other methods, e.g. video conferencing or telephone support.
* Patients referred to us will be discharged when appropriate but can be re-referred back into the service at any time.

**If anything falls outside this remit or you wish to discuss a referral please do call:**

**During working hours: 8am– 5pm (Mon – Fri) Clinical Admin Tel 01284 702525**

**Out of hours: 4pm – 8am (Mon – Sun) Hospice Main Number Tel: 01284 766133**

**OR Weekend mobile (Sat/Sun/Bank holidays 8am - 4pm) Tel: 07791 485101**

**PLEASE REMEMBER** - The **Hospice** teams **can give advice without** requiring a full **referral**. Not ALL individuals at end-of-life require regular Hospice input/referral.

**Please note: We are unable to provide a rapid response service, and referrals can take up to three working days to process; however, should advice be needed before this time, please do call us or link with EIT.**

**St Nicholas Hospice Care** Services Referral Form

24 hour telephone advice available **01284 766133** – Referral Form not required

|  |
| --- |
| **REFERRER DETAILS** |
| **Name** |  | **Date** |  |
| **Job title/** **Relationship** **to patient** |  | **Telephone** |  |
| **Email** |  |
| **PATIENT DETAILS** |
| **Title** |  | **Surname** |  | **First****name** |  | **Middle name** |  |
| **Date of birth** |  | **Male** **[ ]  Female [ ]  Other** [ ]  | **NHS no.** |  |
| **Preferred language** |  | **Ethnicity** |  | **Religion** |  |
| **Address** |  | **Phone number**Please tick to indicate which number is preferred and document whether a message can be left | [ ]  Home:[ ]  Work:[ ]  Mobile: |
| **Who are you****referring?** | [ ]  The patient or[ ]  Family member(s) | **Is patient aware of referral?**The referral cannot be processed unless the patient or advocate is aware of the referral and consent has been given. | [ ]  Yes [ ]  No If no reason why not asked: |
| **Name/relationship to patient** |  | **Family aware of referral** | [ ]  Yes [ ]  No |
| **HAS PATIENT CONSENTED TO SHARE THEIR RECORDS WITH** **ST NICHOLAS HOSPICE CARE** | [ ]  Yes [ ]  No |
| **NEXT OF KIN** |
| **Title** |  | **Surname** |  | **First name** |  |
| **Address** |  | **Relationship to patient** |  |
| **Phone number** |  |
| **MEDICAL** |
| **DIAGNOSIS:****Primary:** |  | **Patient aware of diagnosis**[ ]  Yes [ ]  No**Family aware of diagnosis**[ ]  Yes [ ]  No |
| **Secondary:** |  |
| **Past medical history** |  |
| **My Care Wishes Folder**  | [ ]  Yes [ ]  No | **DNACPR** | [ ]  Yes [ ]  No |
| **Reason for referral** | [ ]  Symptom Control [ ]  Bereavement [ ]  Psychological Support[ ]  Social Crisis [ ]  End of Life Care [ ]  Other (please share details in white space directly below) |
| **MANDATORY DETAILS****(PLEASE INCLUDE)****(including information re: first and second line treatment tried)** |  |
| **Hospice Information leaflet given**(This leaflet can be found on our website with our referral form here: <https://stnicholashospice.org.uk/support-and-information/im-a-medical-professional/referrals/>  | [ ]  Yes [ ]  No [ ]  Not known |
| **Service required** | [ ]  Inpatient Care [ ]  Outpatient/Community |
| **Allergies** | [ ]  Yes [ ]  No [ ]  Not known | If YES please give details: |
| **CDIFF**  | [ ]  +ve [ ]  -ve [ ]  Not known | **MRSA** | [ ]  +ve [ ]  -ve [ ]  Not known |
| **COVID 19** | [ ]  +ve [ ]  -ve [ ]  Not known | **Suspected COVID-19 symptoms (temperature, cough, altered taste?)** | [ ]  Yes [ ]  No [ ]  Not known |
| **Any other****infection risk**  | [ ]  Yes [ ]  No | If YES please give details: |
| **Present location of patient** | [ ]  **Home** | **Are there any hazards in the home?** | [ ]  Yes [ ]  NoIf YES please give details: |
| [ ]  **Hospital** | [ ]  West Suffolk Ward | [ ]  Addenbrooke’s Ward | [ ]  Other ward |
| [ ]  **Care Home** | **Name of care home** |  |
| **Telephone** |  |
| **GP DETAILS**  | **OTHER HEALTHCARE PROFESSIONALS** |
| **GP Name** |  | **Consultants/CNS** | **Hospital** | **Telephone** |
| **Surgery** |  |  |  |  |
| **Tel No** |  |  |  |  |
|  |
| **Any environmental risks** | [ ]  Yes [ ]  No [ ]  Not known | If YES please give details: |