**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:**

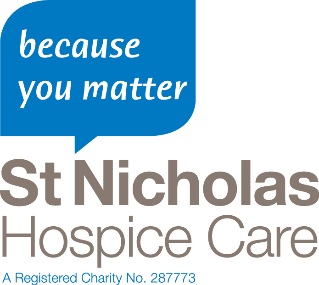
**During working hours: 8am– 5pm (Mon – Fri) Clinical Admin Tel 01284 702525**

**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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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  No  If 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: | | | | |