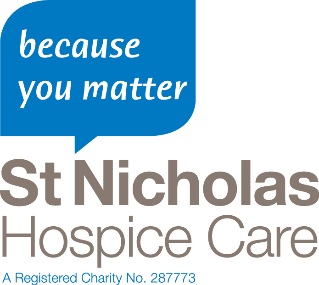
**St Nicholas Hospice Care provides palliative care to people with advanced – life-limiting illness who have complex needs that cannot be addressed or resolved by generalist services. Patients eligible to access our specialist services will have an actively deteriorating condition and/or escalating complex needs.**

Please remember – the hospice can give advice without requiring a full referral. Not all individuals who are palliative or at end-of-life require regular hospice input/referral.

**St Nicholas Hospice Care** Services Referral Form

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

**All sections MUST be completed**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRER DETAILS** | | | | | | | | | | |
| **Name** | | | |  | | **Date** |  | | | |
| **Job title/**  **Relationship**  **to patient** | | | |  | | **Telephone** |  | | | |
| **Email** |  | | | |
| **PATIENT DETAILS** | | | | | | | | | | |
| **Title** | |  | **Surname** |  | **First**  **name** |  | **Middle name** | |  | |
| **Pro noun** | |  |
| **Date of birth** | | | |  | **Male**  **Female  Other** | | **NHS no.** | |  | |
| **Preferred** language | | | |  | **Ethnicity** |  | **Religion** | |  | |
| **Any Disabilities** | | | |  |
| **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 | | | |
| **Who has LPA or family best contact** |  | | | |
| **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 | | **Patient aware of prognosis**  Yes  No  **Family aware of prognosis**  Yes  No | | |
| **Secondary:** | | | |  | |
| **Past medical history** | | | |  | | | | | | |
| **RESPECT form** | | | | Yes  No | | **DNACPR decision** | Yes  No | | | |
| **When should I consider a referral to the Hospice Services?**  Anyone living with a life shortening or advanced chronic disease can be referred. This can be at any time based on the persons’ needs. **Please refer based on the person’s current identified needs.** In our experience referrals for an ‘introduction to the service’ or for general ‘support in the future’ are often declined by the person referred because there is nothing we can assist with at that point. | | | | | | | | | | |
| **Reason for referral** | | | | Symptom Control  Bereavement  Psychological Support  End of Life Care  Other (please share details in white space directly below)  If you are referring to multiple service areas simultaneously, please state why and which is the primary service required. | | | | | | |
| Why is this referral being made now? | | | |  | | | | | | |
| Identify specialist or supportive care needs | | | |  | | | | | | |
| Interventions already taken to address needs | | | |  | | | | | | |
| Other services involved | | | |  | | | | | | |
| **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 | | | | | | |
| **Any other**  **infection risk** | | | | Yes  No | | If YES please give details: | | | | |
| **Present location of patient**  NB: If in hospital, referrals for outpatient / community specialist will be accepted only on or after discharge | | | | **Home** | **Safeguarding risk factors / lone working**  Yes  No | **Are there any hazards in the home?** | Yes  No  If YES please give details: | | | |
| **Hospital** | West Suffolk  Ward: | Addenbrooke’s  Ward: | Other ward (Please give details) | | |
| **Care Home** | | **Name of care home** |  | | | |
| **Telephone** |  | | | |
| **GP DETAILS** | | | | | **OTHER HEALTHCARE PROFESSIONALS** | | | | | |
| **GP Name** | | | |  | **Consultants/CNS** | **Hospital** | **Telephone** | | | |
| **Surgery** | | | |  |  |  |  | | | |
| **Tel No** | | | |  |  |  |  | | | |
|  | | | | | | | | | | |