**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 [ ]  NoIf YES please give details: |
| [ ]  **Hospital** | [ ]  West SuffolkWard: | [ ]  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** |  |  |  |  |
|  |