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| Please ensure that ALL parts of this form are completed in FULL before submitting. If the referral form is incomplete it will be returned for further information and no action will be taken until it is returned successfully completed. Please also attach GP/Hospital discharge summary if appropriate. | | | |
| **Service Required**  CNS Assessment  Day Hospice  Fast Track Care Packages | **Urgency**  Within 24 hours  2-4 days  >5 days | | **Reason for Referral**  Symptom Control  Assessment  End of Life Care  Fast Track Care Packages |
| Referred by: Click here to enter text.  Role: Click here to enter text.  Contact No: Click here to enter text. | | Date of Referral: …  Does patient have health insurance: Yes No  Policy with: …  Policy Number: … | |
| **Title:** Click here to enter text.  **Surname:** Click here to enter text.  **First name:** Click here to enter text. | | **DOB:** Click here to enter text. **Ethnicity** Click here to enter | |
| **NHS No:** Click here to enter text. | |
| Address: Click here to enter text.  Tel No: Home: Click here to enter text.  Mobile: Click here to enter text. | | Next of Kin/Carer name: Click here to enter text.  Relationship: Click here to enter text.  Contact Tel No: Click here to enter text. | |
| Current location:  Home  Hospital  Nursing Home  … Other | | Diagnosis & Co-morbidities  Click here to enter text. | |
| DNACPR / ReSPECT  Anticipatory Medicines | |
| Name of GP: Click here to enter text.  Surgery: Click here to enter text.  Tel No: Click here to enter text. | | Other agencies/professionals involved (please give name and contact details):  DN: …  CNS: …  Community Matron: …  Social services/Care agency: …  Other: … | |
| Consultant Name & Hospital (if relevant):  Click here to enter text. | | Any communication difficulties?  Click here to enter text. | |
| **Please state expected outcome of referral and current issues for patient:**  Click here to enter text.  Has patient consented to referral? Yes  No | | | |
| **Additional information and past medical history:**  Click here to enter text. | | | |
| **Current nursing needs:** …  Cognitive impairment? Yes  No  Details: …  Height/weight extremes? Yes  No  Details: …  Risk of wandering? Yes  No  Details: …  Infection control issues? Yes  No  Details: …  Falls risk? Yes  No  Details: …  Smoker? Yes  No  Details: …  On home O2? Yes  No  Details: …  **Tissue Viability**  Pre-existing pressure ulcers? Yes  No  Details: …  High risk ulcers? Yes  No  Details: …  Any other skin breaks? Yes  No  Details: … | | | |
| Family and home situation: Lives alone  Lives with… Click here to enter text.  Equipment in Home:  Hospital bed  Walking aids  Commode  Care arrangements in place or in process of being planned (any referrals already made?): ….  Fast Track Funding  Social Care  Details of above: Click here to enter text. | | | |

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| **OFFICE USE ONLY**  Referral taken by: Name: Role: Date: | |
| **Outcome**   1. Accepted 2. Refused on clinical grounds 3. Withdrawn | 1. Refused on other grounds (specify) 2. Death 3. On hold |