Specialist Palliative Care Referral Form - BLMK  
Please tick service required

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| **Willen Hospice Palliative  Care Service**  Tel: 01908 663 636 [willen.hospice@nhs.net](mailto:willen.hospice@nhs.net) | **Sue Ryder St John’s Hospice**  Tel: 01767 642410 St John’s  Inpatient referral advice line:  01767 669855  01767 641349 PCHUB  [stjohns.referrals@nhs.net](mailto:stjohns.referrals@nhs.net) | **Keech Hospice Care**  Tel: 0808 180 7788 mycarecoordinationteam@nhs.net |
| **Luton Community Service (CCS)**  Tel: 0333 405 3000  [ccs-tr.lutonrmsreferrals@nhs.net](mailto:ccs-tr.lutonrmsreferrals@nhs.net) | | **Bedfordshire Community Service (ELFT)**  Tel: 0345 6024064 singlepoint.ofcontact@nhs.net |

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| **Any urgent referrals and requests for admission should be accompanied by a phone call**  We may contact you for further clarification or to discuss the most appropriate plan of action for the patient. |

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| **The patient’s current location: (eg Hospital/Home)** |
| **Hospital Name: Hospital Ward: Date of Discharge:** |
| **REFERRER’S NAME JOB TITLE CONTACT NUMBER:**  **Referrer’s signature: Date:** |

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| **Surname:** | **Male  Female  Other** |
| **First name:** | **Known as:** |
| **Address:**  **Postcode:**  **Email:** | **DIAGNOSIS:**  **DATE of DIAGNOSIS:** |
| **Home Tel.:**  **Mobile Tel.:** | **NHS number:**  **DOB:** |

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| **MAIN CARER:**  **Relationship to patient:**  **Tel:**  **Who does the patient live with?** | | **NEXT of KIN** (if different):  **Relationship to patient:**  **Tel:** | |
| **Main Language: Interpreter needed? Yes/No**  **Religion: Ethnic origin: Occupation:** | | | |
| **GP NAME:**  **Is GP aware of referral? Yes/No** | **Tel:**  **Email:** | | **Surgery Name:** |
| **DISTRICT NURSE involved Yes/No** | **Known to:** | | **Based at:** |
| **Name of other Specialist Service involved:** | **Name of staff member:** | | **Tel:**    **Email** |
| **Funding for care approved: Yes /No** If in progress please forward application paperwork **Approval for: Fast Track CHC (Nursing Home)  (Home)  Social care** | | | |

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| **Does the patient have capacity to make decisions: Yes/No**  **If No, please complete Mental capacity assessment and Best interest documentation**  **Has the patient consented to referral to Specialist Palliative Care: Yes/No**  **Does the patient have LPA: Health Yes/No Finance: Yes/No**  **Has the patient consented to share information? Yes/No Has SystmOne been shared? Yes/No** |

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| **Have any advance care planning discussions taken place, including discontinuation of treatments and escalation plans? YES/NO**  **If yes, what outcomes: PPC: PPD:**  **Is DNACPR IN PLACE? YES/NO Is patient on EPaCCS? YES/NO** |

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| **BRIEF HISTORY of CURRENT ILLNESS and KEY TREATMENTS** |
| History, tests and treatment |
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| **ALLERGY/SENSITIVITY:** |
| **MRSA Status ………... C. Diff Status …………. Covid 19………… Other infection……………** |
| **WHAT ARE THE KEY CONCERNS THAT REQUIRE SPECIALIST PALLIATIVE CARE INPUT?**  **What has the patient been told about this referral?** |
| **VULNERABILITIES/RISKS TO BE AWARE OF IN THE COMMUNITY: (eg safeguarding concerns, living conditions, family dynamics, access)** |
| **Does the patient have pressure ulcers? YES/NO If YES Category …………… Reported: YES/NO**  **Falls Risk? YES / NO**  **Date of last fall………**  **Mobility: Equipment:**  **Approximate Weight: below 50kg  50-80kg  90-110kg  120-140kg  150kg or above  Approximate Height: 145-155cm  165-175cm  185-195cm** |
| **Oxygen (Including anticipated rate required)  …………..**  **Suction  CVAD  NIPPV  Syringe Driver  Feeding pump  Tracheostomy/ Laryngectomy** |
| **OACC - Patients current Karnofsky Performance Status: ……………% OR**  **Performance score:0-5 ……………**  **Phase of Illness –** *please* 🗸Stable  Unstable  Deteriorating  Dying |

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| **Main Reasons for Referral -** *please* ✓  Care in the last days of life  Social/financial support (family/carer)  Symptom control  Social/financial support (patient)   Emotional/psychological/spiritual support (patient)  Other (please specify)  Emotional/psychological/spiritual support (family/carer) | | |
| **Service requested -** *please* ✓ Subject to assessment | | |
| **Willen Hospice**  Willen at Home Team  Inpatient Care  Therapeutic and Wellbeing Service | **St John’s Hospice**  Inpatient Unit  Medical Outpatient  Day Therapy including Lymphoedema Clinic  (Own transport required for Day Therapy and Outpatient Service) | **Keech Hospice Care**  Inpatient Care  **Wellbeing Centre**  Nurse led clinic  (including blood transfusions)  Rehab  (Physio, OT and Hydrotherapy)  Social Work and  Supportive Care Team  (creative and talking therapy work, bereavement support, carer support, hospice at home volunteers and complementary therapy) |
| **Community Specialist Palliative Care Team**  **CCS** (Luton) **Macmillan SPC CNS Team  CCS** (Luton) **benefits team  ELFT** (Bedfordshire) | | |
| **24hr Advice and Support Line** (Verbal consent gained)  **Palliative Care Hub  My Care Coordination Team** | | |

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Registered charity number 1035089

Registered charity number 1052076

Registered charity number 270194



