

**PATIENT REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE Private & Confidential**

## *Referral Criteria*

* **Patient has progressive, life limiting diagnosis**
* **has complex problems that cannot be adequately addressed by current caring team**
* **has a reasonable understanding (where appropriate) of their illness and accepts referral to specialist palliative care services**

**BEFORE REFERRING TO TRINITY PLEASE ENSURE THAT BASIC SYMPTOM CONTROL MEASURES AND EMOTIONAL SUPPORT IS BEING PROVIDED BY THE PATIENT’S CURRENT CARING TEAM**

**(i.e. PRIMARY HEALTH CARE TEAM OR HOSPITAL TEAM)**

**PLEASE NOTE: PLEASE USE E-REFERRALS FOR REFERRALS TO THE HOSPITAL PALLIATIVE CARE TEAM AT BTH**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | | |
| Patient name:  Known as:  Address:  Post Code:  Tel No:  Date of Birth:  NHS No:  Hospital No: |  | | | Is the patient at home: | | | | | Yes  No |
| Location if not at home:  If patient in hospital please specify Ward: | | | | | |
| Does the patient live alone: | | | | | Yes  No |
| Patient aware of and agrees to the referral: | | | | | Yes  No |
| Family aware of and agree to the referral: | | | | | Yes  No |
| **Carer / Next of Kin details** | | | | | |
| Name of main carer / Next of Kin:  Relationship to patient:  Contact details: *(if applicable)* | | | | | |
| **GP and Surgery Details** | | | | | | | | | |
| General Practitioner: | | | | |  | | Is the GP aware of referral? Yes  No | | |
| Surgery Address: | | | | |  | | Is the DN team involved? Yes  No | | |
| Telephone Number: | | | | | | ***(IF NO, PLEASE REFER)*** | | | |
| **Diagnosis of current problems** | | | | | | | | | |
| **Life limiting diagnosis is:** | | | | | | | | **Approx Date of Diagnosis**: | |
| **Other relevant medical conditions:** | | | | | | | | | |
| **Summary of Treatment to date and future planned treatment:** | | | | | | | | | |
| **Other relevant information, e.g. psychological, social issues:** | | | | | | | | | |
| **Advance Care Planning** | | | | | | | | | |
| Is the patient on Gold Standards Framework Register: | | | Yes  No | | | | | | |
| If **Yes**, where is the preferred place of care: | | Home  Nursing Home  Hospice  Hospital | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Patient Name: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other professionals involved *(name and telephone number)*** | | | |
| Consultant(s): | | | |
| CNS/Matron: | District Nurse: | | |
| Social Services: | Other: | | |
| **Reason for referral and type of input requested. Please give details of specific problems requiring *Specialist Palliative Care* input and interventions required and supportive measures currently in place**: | | | |
| **If you feel there is an URGENT need for our input, please contact the palliative care team to**  **discuss on 01253 359379, after ensuring that the generalist nursing team are involved.** | | | |
| **PLEASE INCLUDE COPIES OF CURRENT MEDICATION LIST AND RELEVANT CLINIC LETTERS, ONCOLOGY ANNOTATIONS, ETC.** | | | |
| **Please ensure that all relevant information has been given to avoid a delay in processing this referral.**  **Incomplete forms will be returned to you.** | | | |
| **Referrer’s Details *(Form must be signed by GP, Senior Hospital Doctor, Clinical Nurse Manager or CNS)*** | | | |
| Name of Referrer: *(PRINT)* | | Designation: | Date of Referral |
| Signature or Email address of Referrer: | | Contact number: |  |
|  | |  | |

**Completed referrals should be emailed to:**

**Telephone: 01253 359379 Email:** [**trinity.referrals@nhs.net**](mailto:trinity.referrals@nhs.net)

Website: [**www.trinityhospice.co.uk**](http://www.trinityhospice.co.uk) (includes Health Professionals Guidance)