

**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**

**All referrals must be typed and received in either PDF or WORD format.**

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| **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)*** ***GST status*** ***RED***  [ ]   ***AMBER***  [ ]  ***GREEN***  [ ]   ***BLUE***  [ ]   |
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**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 [ ]   |

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| Patient Name:  |       |  |

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| **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 952566, 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:       |       |
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**Completed referrals should be emailed to:**

**Telephone: 01253 952566 Email:** **trinity.referrals@nhs.net**

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