

## Rapid Response Hospice at Home Referral Form

<b>Date:</b>				<b>Time:</b>				<b>Crisis:</b>				<b>Planned:</b>			
<b>Referred by:</b>								<b>Locality:</b>							
<b>Role:</b>								<b>Contact details:</b>							
<b>Has the patient/carer agreed to the referral?(please circle)</b>										<b>Yes</b>		<b>No</b>			
<b>Does the patient have continuing care funding?(please circle)</b>										<b>Yes</b>		<b>No</b>			
<b>Does the patient live alone?</b>										<b>Yes</b>		<b>No</b>			
<b>Patient details</b>															
<b>Name:</b>				<b>Title:</b>				<b>DOB:</b>				<b>Age:</b>			
<b>Address:</b>															
<b>Postcode:</b>						<b>Telephone No.</b>									
<b>Next of Kin:</b>						<b>Relationship:</b>									
<b>NOK Contact details:</b>															
<b>Main Carer:</b>						<b>Relationship:</b>									
<b>Contact details:</b>															
<b>Community Nurse:</b>						<b>Contact No.</b>									
<b>GP:</b>						<b>Contact No.</b>									
<b>Care manager:</b>						<b>Contact No.</b>									
<b>Diagnosis:</b>															
<b>Prognosis:(please circle) Imminently dying 1wk 1-2wks 2-4wks Unsure</b>															
<b>Is the patient aware of the diagnosis? Yes/no Aware of the prognosis? Yes/no</b>															
<b>Is the NOK aware of the diagnosis? Yes/no Aware of the prognosis? Yes/no</b>															
<b>Patients preferred place of care is?</b>															
<b>Patients preferred place of death is?</b>															
<b>NOK/Carers preferred place of care for patient is?</b>															
<b>NOK/Carers preferred place of death for patient is?</b>															

<b>Reason for referral: (please circle)</b>	
<b>Facilitate hospital discharge</b>	<b>Facilitate hospice discharge</b>
<b>Prevent hospital admission</b>	<b>Prevent hospice admission</b>
<b>Carer ill</b>	<b>Carer respite</b>
	<b>Carer emotional/psychological support</b>
<b>Patient emotional/psychological support</b>	<b>Symptom control needs</b>
<b>Requires extended nursing care</b>	<b>Support dying at home</b>
<b>Summary of relevant past medical history:</b>	
<b>Summary of main problems:</b>	
<b>Is the patient semi-comatose? Yes/no</b>	
<b>Is the patient bed bound? Yes/no</b>	
<b>Is the patient only able to take sips of fluids? Yes/no</b>	
<b>Is the patient unable to take oral medication? Yes/ no</b>	
<b>Is the patient continent? Yes/no</b>	
<b>Which symptoms are of concern? Please circle</b>	
<b>Anxiety</b>	<b>Agitation</b>
<b>Breathlessness</b>	<b>Confusion</b>
<b>Constipation</b>	
<b>Fatigue</b>	<b>Nausea</b>
<b>Pain</b>	<b>Vomiting</b>
<b>Other – describe</b>	
<b>Is the patient able to self - medicate?</b>	
<b>Medication route: Please select: Oral Patches Injections Syringe Driver Peg</b>	
<b>Is there a care plan in the home? Yes/no</b>	
<b>Is the patient on the GSF register? Yes/no</b>	
<b>Is the patient on the LCP? Yes/no</b>	
<b>What would the likely outcome be if the RRHaTH cannot meet the care requested? i.e. Can an alternative cover be provided? Admission of patient? Family manage?</b>	
<b>For office use only: Response to referrer: Accepted Not Accepted</b>	
<b>Date and time services started:</b>	
<b>Date and time service completed:</b>	
<b>Reason for completion of care: Died Revised care package</b>	
<b>Admitted hospital</b>	<b>Admitted hospice</b>
	<b>No longer required</b>