 **Hospice at Home personal care**

**Request Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** | **Time:** | | **Crisis** or **Planned?** |
| **Referred by:** | | **Locality:** | |
| **Role:** | | **Contact details:** | |

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| Has the patient / carer agreed to the referral?  Does the patient live alone?  Has a fast track CHC been completed?  **Who by?** |

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| --- | --- | --- | --- |
| **Patient details** | | | |
| Name: | Title: | DOB: | Age: |
| Address: | | | |

**Prognosis:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Imminently dying? |  |  | 1wk |  |  | 1-2wks |  |
| 2-4wks |  |  | Unsure |  |  |  |

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| **Patient’s preferred place of care is?** |

**Reason for referral:**

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| --- | --- | --- | --- | --- |
| Facilitate **hospital** discharge |  |  | Facilitate **hospice** discharge |  |
| Prevent **hospital** admission |  |  | Prevent **hospice** admission |  |
| Carer ill |  |  | Carer respite |  |
| Carer emotional / psychological support |  |  |  |  |
| Patient emotional / psychological support |  |  |  |  |
| Symptom control needs |  |  | Requires extended nursing care |  |
| Support dying at home |  |  |  |  |

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| **Summary of main problems:** |

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| Is the patient semi-comatose? |  |
| Is the patient bed bound? |  |
| Is the patient only able to take sips of fluids? |  |
| Is the patient unable to take oral medication? |  |
| Is the patient continent? |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Which symptoms are of concern?** | | | |  |
| Anxiety | Agitation | Breathlessness | Confusion | Constipation |
| Fatigue | Nausea | Pain | Vomiting |  |
| Other – please describe: | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication route:** | | | | |
| Oral | Patches | Injections | Syringe driver | Peg |

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| What would the likely outcome be if Hospice at Home cannot meet the care requested?  *i.e.* Can alternative cover be provided? Admission of patient? Family manage? |