Pilgrims Hospice Referral Form

Completed Forms to Be Emailed to: PH.PilgrimsHospices@nhs.net

ALL FIELDS ARE MANDATORY

To avoid delay please ensure this form is completed in full

PATIENT DETAILS							
Surname:		First Name:					
D.O.B.:		Age::					
Gender		NHS No.:					
Has the patient gone under any gender re-assignment treatment/surgery?			☐ Yes	☐ No	☐	Prefer not to say	
If **yes** give details							
Pronouns	☐	He/him/his	☐	She/her/hers	☐	They/them/their	☐ **Other** please give details
Address:							
Post code:							
Home Tel.:		Mobile:					
Email:							
Interpreter required?	☐ Yes	☐ No		First Language:			
Communication Difficulties		Preferred Communication Method	e.g. text/email				
Current Place of Care	☐ Home	☐ Care Home	☐ Hospital	☐ Other	If **other** please add details		
	Name:						
	Ward/Unit:		Tel. No.:				
Address of current place of care (if different from above)							

GP DETAILS			
Name:		Code:	
Tel. No.:		Email:	
Address			

NEXT OF KIN DETAILS			
Relationship to Patient:		Full Name:	
Home Number:		Address:	
Mobile Number:			

MAIN CARER DETAILS (if Different to Next of Kin)			
Relationship to Patient:		Full Name:	
Home Number:		Address:	
Mobile Number:			

PATIENT AND NEXT OF KIN CONFIRMATION	
☐ Patient has confirmed their details are correct	☐ Next of Kin is aware they have been included and details are correct

Children under 18 and Dependents (with a significant relationship to patient)		
☐ Children under 18	☐ Other dependants	☐ No
Please give details		

REFERRAL SOURCE					
☐ GP	☐ Hospital	☐ Family	☐ Self-referral	☐ Other (please specify)	
Hospital/Practice (if applicable):					
Full Name:					
Office Number:		Email Address:			
Mobile Number:					

PERSON COMPLETING FORM (If different from above)			
Name:		Hospital:	
Office Number:		Email Address:	
Mobile Number:			

URGENCY OF THE REFERRAL. To be contacted (tick which one applies)		
☐ Within 24 hours	☐ Within 48-72 hours	☐ Within 7 days

PATIENT CONSENT

I confirm the following:
I have discussed the referral to the hospice for support with end of life care and the patient has consented and understands that Pilgrims may need to access the relevant information on their GP record. The patient is aware that they will be contacted by a member of staff from the hospice. If the patient lacks capacity the referral must be made in Best Interests of patient in conformance with Mental Capacity Act.

Name:		Role:		Date	

Best Interest Decision Maker Name (if relevant):

ADDITIONAL PATIENT INFORMATION

Mental Capacity	Is patient able to make simple day to day choices and decisions?	☐ Yes	☐ No	
	Is patient able to make complex decisions about treatment & care?	☐ Yes	☐ No	
	Is there an LPA for Health & Welfare?	☐ Yes	☐ No	If yes, full name and contact details?
	Is there an LPA for Property & Financial Affairs?	☐ Yes	☐ No	If yes, full name and contact details?

Safeguarding Issues	☐ Yes	☐ No	Additional Info:	
DOLS	☐ Yes	☐ No	Additional Info:	

FUNDING AGREEMENTS			
Is the patient CHC Fastrack funded?	☐ Yes	☐ No	☐ Don't Know
Is the patient CHC long route funded?	☐ Yes	☐ No	☐ Don't Know
Has a Decision Support Tool (DST) checklist been completed?	☐ Yes	☐ No	☐ Don't Know
Is the patient Social Services funded?	☐ Yes	☐ No	☐ Don't Know

DIAGNOSIS AND CURRENT ISSUES (Additional Information from EMIS Record Below)

Primary Diagnosis

Is the primary diagnosis Cancer on Non-cancer? ☐ Cancer ☐ Non-cancer

Further Diagnosis and Current Issues

ADVANCED CARE PLANNING			
Is there a DNACPR form in place?	☐ Yes	☐ No	
Is there a ReSPECT form in place?	☐ Yes	☐ No	

PATIENT CLINICAL INFORMATION FROM MERGED GP ELECTRONIC RECORDS	
Allergies:	
Active Problems:	
Investigations:	
Significant past history:	
Current medication:	
Repeat medication:	

PATIENT'S GOALS (Please discuss with patient)	
What is important to you right now?	
What would you like to achieve in the next short while?	
What have been your main problems or concerns over the past 3 days?	

ARE YOU REQUESTING A HOSPICE INPATIENT ADMISSION? (If yes please complete section 2)		
Inpatient Admission	☐ Yes	

Section 2 – *Only complete if the patient requires admission to a Pilgrims Hospices' inpatient unit.*

In your opinion, can this patient be safely looked after in a normal bed in a unit with a maximum of 3 nursing staff and no overnight medical cover?		
☐ Yes	☐ No	If the answer is no, please call the ward and speak to the nurses.
Reason for admission:		

ADDITIONAL PATIENT INFORMATION			
Falls Risk/Mobility Issues/ Needs more than two to deliver care or move	☐ Yes	Additional Info:	
Infection Issues/Barrier Nursing	☐ Yes	Additional Info:	
Delirium/confusion	☐ Yes	Additional Info:	
Syringe Driver or Medicine Patch	☐ Yes	Additional Info:	
Pressure Ulcers	☐ Yes	Additional Info:	
Oxygen therapy	☐ Yes	Additional Info:	
Bariatric, do they need bariatric equipment (Canterbury Only)	☐ Yes	Additional Info:	
Tracheostomy/ Laryngectomy (Ashford site only)	☐ Yes	Additional Info:	
Complex family dynamics	☐ Yes	Additional Info:	