 **Teesside Hospice**

 **Inpatient Unit referral**

***Does the patient you are referring meet the referral criteria*:** [ ] YES [ ] NO

*This information can be found on our website: (https://www.teessidehospice.org/clinical-referral-information) If the patient does not meet the criteria, please contact 01642 811072 to discuss the patient.*

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| Section 1 (required): PATIENT DETAILS  |
| ***Patients name (Inc title):***  | ***DOB:*** | Click or tap to enter a date. |
| ***Patients main address including postcode:*** | NHS No: |  |
| Patients Tel. No: |  |
| ***Has the patient consented to the referral***: | [ ] YES [ ] NO (*If no enter the reason in the text box)* Click or tap here to enter text. |
| ***Patient current location****:* | Choose an item. (*Please state hospital/ward/care home)*Click or tap here to enter text. |
| ***Marital status*** | Choose an item. |
| ***Ethnic origin:*** | Please select  |
| ***Religion*:** | Choose an item. |
| ***Lives alone:*** | YES [ ]  NO[ ]   |
| ***GP Details:*** |  |
| ***Are there any identified risks posed to health professionals e.g. acts of threats of violence, pets, safeguarding etc:*** | YES[ ]  NO[ ]  **Please state:** |
| ***Patient diagnosis and PMH*** |  |
| ***Prognosis*** | Choose an item. | ***Is the patient aware of prognosis:*** | Choose an item. |
| ***Service Required:*** | Choose an item. | ***How soon is the service required:*** | Choose an item. |

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| Section 2 (required): Carer details  |
| ***Main carer (name and relationship):*** |  |
| ***Main carer telephone number*:** |  |
| ***Is NOK different to main carer? If so, please provide details:*** |  |

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| Section 3 Patient information (required):  |
| **Symptoms (Please click all that apply)**Pain[ ]  Nausea/vomiting [ ]  Constipation [ ]  Breathlessness [ ] Agitation/restless [ ] Psychological Distress [ ]  Poor mobility [ ] Approaching end of life [ ] ***Other please State:*** Click or tap here to enter text. | ***Severity of symptoms*:** | Choose an item. |
|  | ***Phase of illness*:** | Choose an item. |
|  | ***Karnofsky score:*** | Choose an item. |
| ***Is there a discrepancy between care needs and care arrangements*:** | [ ]  Yes / [ ]  No / Impending[ ]  |
| ***Any extra information click all that applies to the patient:*** | Oxygen[ ]  Enteral feeding [ ]  Intravenous regime [ ] Specialist equipment e.g. Alternating Mattress / Bariatric bed [ ]  NIV[ ]   Other please state:Click or tap here to enter text.  |
|  ***Patient’s nutritional status*:** |  Choose an item. |
| ***Has the patient got any swallowing problems****:* | YES [ ]  NO[ ]  Please state: Click or tap here to enter text. ***Enteral feeding****:* Choose an item.  |
| ***Has the patient got any Infections*** | Choose an item. |
| ***Please state the infection:*** | Click or tap here to enter text. |
| ***Is patient symptomatic of infection :*** | [ ] Yes / [ ]  No  |
| ***Advanced Care Planning:*** | DNACPR [ ]  Respect form [ ]  EHCP [ ]  ADRT [ ]  LPA[ ]  |
| ***Please provide details of LPA (health or/and welfare name of attorney):*** | Click or tap here to enter text. |
| ***Preferred place of Care*:** | Choose an item. |
| ***Preferred place of Death*:** | Choose an item. |
| ***Anything other information*:** |  |

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| Section 4(required): Refer details  |
| **Referred by** (referrer’s name): |  | **Date of referral:** |  |
| **Organisation or Department:** |  |  **Contact Tel no:** |  |

***Thank you for completing the referral, please ensure this form is completed to the best of your knowledge this will help us prioritise.***

***Please email this form to:*** ***stees.teessidehospice.cas@nhs.net***

***Urgent referrals aim to be addressed within 24hours however please ring the inpatient unit 01642 811061 as soon as possible. Routine referrals aim to be addressed within 3 working days.***