A logo for a hospital

AI-generated content may be incorrect. **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***](mailto: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.***