Specialist Palliative Care (SPC) Community and SPC Inpatient Unit Referral Form (1/3)

Specialist Palliative Care Community Teams & Inpatient Units across South & West London

Greenwich & Bexley Community Hospice Bostall Hill, Abbey Wood **SE2 0GB** Home care: Tel: 020 83205837 Fax: 020 83205839 Admissions: Tel. 020 83122244 Fax: 020 83124344	**Lewisham Macmillan Community Team:** Lewisham High Street **SE13 6LH** Tel: 020 8333 3017 Fax: 020 8333 3270	**St Christopher's Hospice** Lawrie Park Rd, London **SE26 6DZ** Home care: Tel: 020 8776 5656 Fax: 020 87765798 Admissions: Tel. 020 87684582 Fax: 02086595051 St Christopher's Bromley Tel: 01689 825755 Fax: 01689 892999
Guy's & St Thomas' Community Team: Guy's Hospital, Great Maze Pond **SE1 9RT** Tel: 020 71884754 Fax: 020 71884748	**Meadow House Hospice** Southall **UB1 3HW** Tel: 020 89675179 Fax 020 89675756	**St John's Hospice** Grove End Road, St John's Wood **NW8 9NH** Tel:020 78064040 Fax: 020 78064041
Harlington Hospice St Peter's Way, Harlington **UB3 5AB** Tel: 020 87590453 Fax: 020 87590600	**Michael Sobell House** Northwood, Middlesex **HA6 2RN** Tel:01923 844531 Fax: 01923 844565	**St Luke's Hospice** Kenton Road, Harrow **HA3 0YG** Tel: 020 83828001 Fax: 020 83828080
Harrow Community Team Kenton Road, Harrow **HA3 0YG** Tel: 020 83828084 Fax: 020 83828085	**Pembridge Palliative Care Centre** Exmoor Street, **W10 6DZ** Tel: 020 8962 4410 Inpatient Fax: 020 89624422 Community Services Fax: 020 89624413	**St Raphael's Hospice** London Road, North Cheam **SM3 9DX** Tel: 020 80997777 Fax: 020 8099 1724
Hillingdon Community Team Pield Heath Road, Uxbridge **UB8 3NN** Tel:01895 279412 Fax: 01895 279452	**Princess Alice Hospice** West End Lane, Esher **KT10 8NA** Tel: 01372 461804 Fax: 01372 470937	**Trinity Hospice** Clapham Common **SW4 0RN** Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065 Fax: 020 7787 1067

For further information and advice on these services, please visit the Help the Hospices service directory at:
http://www.helpthehospices.org.uk/about-hospice-care/find-a-hospice/uk-hospice-and-palliative-care-services/
and enter the postcode provided above.

Every LCA hospital has a Specialist Palliative Care team;
if your patient is a *hospital inpatient,* please contact the team, via the relevant hospital switchboard.

FAX MESSAGE	
From:	**To:**
Fax No:	**Date:**
No. of pages (incl cover sheet):	
Additional information	

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM – including recent clinic letters, blood tests and most recent imaging

NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT

PATIENT NAME …… **NHS No:**……

LONDON CANCER ALLIANCE West and South LCA

Referral Form for SPC Community and Inpatient Units (2/3)

Essential Patient Details

Surname	Male/Female Age:	Patient consent to palliative care involvement? Yes ☐ No ☐
First Name	DoB	Is GP aware of referral? Yes ☐ No ☐
Address		
Postcode	Marital Status	Ethnicity
Tel	Mob	
NHS number	**Hospital No.**	

Primary diagnosis(es)

Communication	Other barriers to communication / registered disabilities:
Fluent in English? Yes ☐ No ☐ (If 'no' proceed with remaining questions)	
First Language, if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes ☐ No ☐	

Next of Kin/Patient Representatives	**District Nurse Yes ☐ No ☐**	**General Practitioner**
Name	Name	Name
Address	Based at	Address
	Telephone	
Telephone	Fax	
Relationship to patient		Postcode
Main Carer (if different from above) Name	**Social Services Yes ☐ No ☐** Name	Telephone
Telephone	Based at	Fax/email
Relationship to patient	Tel Fax	CCG:
	Continuing care assessment completed: Yes/No	
	Continuing care funding agreed: Yes/No	

Reason for Referral	**Service requested**	**The patient is currently**
Pain/symptom control..... ☐	Home assessment and support..... ☐	At Home..... ☐
Emotional/psychological support..... ☐	Hospital assessment ..... ☐	In Hospital (see over)..... ☐
Social/financial..... ☐	Day Care..... ☐	Other e.g. Nursing Home..... ☐
Assessment for hospice admission..... ☐	Outpatient service..... ☐	Please specify.....
Carer support..... ☐	Admission (circle)..... ☐	
Other reason *(please give details below)*..... ☐	Respite / symptom control / terminal care	Does patient live alone? Yes ☐ No ☐
.....	Hospice at Home..... ☐	

Any access issues (e.g. key safe):

MRSA Status	**Any other communicable infection:**
Positive ☐ Negative ☐ Not known ☐	.....

Special device in situ? Yes ☐ No ☐ If yes, give details (e.g. trache / PEG / ICD / NIPPV):.....

Referrer's Name: (please print)	**Contact number:** **Bleep no:**
Hospital/Surgery:	**This information required on both pages if faxing**

IS REFERRAL URGENT (assess within 2 working days)? Yes ☐ No ☐

IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

LONDON CANCER ALLIANCE West and South LCA

Referral Form for SPC Community and Inpatient Units (3/3)

In-Patient details	**Patient Name:**
Hospital	NHS No:
Ward Direct Ward Ext.	Telephone
Key worker	Date of discharge (if known)
Consultant	Is Palliative Care team involved? Yes ☐ No ☐

Brief History of diagnosis(es) and Key treatments

Date	Progression of disease and investigations/treatment	Consultant and hospital

Current palliative care problems	
1.	4.
2.	5.
3.	6.
Patient Mobility:	**Bariatric Nursing required?** Yes ☐ No ☐

Any other comments/information (including preferences expressed about care or other psychosocial or spiritual issues)

Referrer's expectation of current treatment *(please circle)* symptom control / life prolonging / curative

Prognosis: In your opinion, is the patient

Stable? Yes ☐ No ☐ **Unstable?** Yes ☐ No ☐ **Deteriorating?** Yes ☐ No ☐ **Dying?** Yes ☐ No ☐

Is death anticipated within: Months ☐ Weeks ☐ Days ☐

Patient on Coordinate My Care? Yes ☐ No ☐ Unknown ☐ If not please give reason……

On the GSF register? Yes ☐ No ☐ Unknown ☐ **DNACPR in place?** Yes ☐ No ☐

Past Medical and Psychiatric History	**Current Medication**	
		Known Drug Sensitivities/Allergies:
		Yes ☐ **No** ☐
		Details:

Insight: Has patient been told diagnosis? Yes ☐ No ☐ **Is the carer aware of patient's diagnosis?** Yes ☐ No ☐

Does patient discuss the illness freely Yes ☐ No ☐

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature:	**Name:** (please print)
Job title:	**Contact number:** **Bleep no:**
Surgery or Hospital:	**Date:**