



Specialist Palliative Care Community Teams & Inpatient Units across NC & NE London

<input type="checkbox"/> Islington ELiPse Community Palliative Care Team St. Pancras Hospital, 5 th Floor South Wing, 4 St Pancras Way, London NW1 0PE Tel: 020 3317 5777 Email: palliative.islington@nhs.net	<input type="checkbox"/> Saint Clare Hospice: Hastingwood Rd, Hastingwood, Harlow CM17 9JX Tel: 01279 773700 Email: SCLHO.referrals@nhs.net	<input type="checkbox"/> South Camden Palliative Care Team St. Pancras Hospital, 5 th Floor South Wing, 4 St Pancras Way, London NW1 0PE Tel: 020 3317 5777 Email: Palliative.southcamden@nhs.net
<input type="checkbox"/> Marie Curie Hospice Hampstead: 11 Lyndhurst Gardens NW3 5NS Tel: 020 7853 3400 Email for inpatient unit & day therapy: InpatientUnit.HampsteadHospice@nhs.net / daytherapyunit.hampsteadhospice@nhs.net	<input type="checkbox"/> Saint Francis Hospice Broxhill Road, Havering-Atte-Bower, Romford RM4 1QH Tel: 01708 758606 Email: NELCSU.saintfrancishospicereferrals@nhs.net	<input type="checkbox"/> The Margaret Centre Whipps Cross Hospital, Whipps Cross Rd, Leytonstone E11 1NR Tel: 020 8535 6605 Email: BHNT.margaretcentreferrals@nhs.net
<input type="checkbox"/> North London Hospice 47 Woodside Avenue N12 8TT Tel: 020 8343 8841 Email: triage.team@nhs.net	<input type="checkbox"/> Saint John's Hospice Grove End Road, St John's Wood NW8 9NH Tel: 020 7806 4040 Email: Cfccg.stjohnsreferrals@nhs.net	<input type="checkbox"/> The Royal Free Palliative Care Team Royal Free Hospital, Pond Street, London NW3 2QG Tel: 020 78302905 Email: rf.palliativecare@nhs.net
<input type="checkbox"/> Redbridge Community Palliative Care Team Hainault Health Centre, Manford Way, Chigwell, IG7 4DF Tel: 0300 300 1901 Fax: 020 8430 8466 Email: Nem-tr.Redbridgespecialistpalliativecareteam@nhs.net	<input type="checkbox"/> Saint Joseph's Hospice Mare Street, Hackney E8 4SA Tel: 0300 30 30 400 Email: stjosephs.firstcontact@nhs.net	

For further information and advice on these services, please visit the Hospice UK service directory at:

<http://www.hospiceuk.org/about-hospice-care/find-a-hospice> and enter the postcode provided above.

Every 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	
<p>Confidentiality: The content of this fax and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above.</p>	
<p>PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM</p> <p>– including recent clinic letters, blood tests and most recent imaging.</p> <p>NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT</p>	

PATIENT NAME

NHS No.



Essential Patient Details			
Surname	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Patient consent to palliative care involvement? Yes <input type="checkbox"/> No <input type="checkbox"/> Best interest <input type="checkbox"/>
First Name	DoB	Age:	Is GP aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address			
Postcode	Marital Status married	Ethnicity	
Tel.	Mob.		
NHS number	Hospital No.		

Primary diagnosis(es)

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

Next of Kin/Patient Representatives	District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	General Practitioner
Name not stated no N.O.K recorded	Name	Name
Address	Based at	Address
Postcode	Telephone	
Telephone	Fax	
Relationship to patient		Postcode
Main Carer (if different from above)	Social Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Telephone
Name	Name	Fax/Email
Telephone	Based at	CCG:
Relationship to patient	Tel	
	Fax	
	Continuing care assessment completed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Continuing care funding agreed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for Referral	Service requested	The patient is currently
Pain/symptom control <input type="checkbox"/>	Home assessment and support. <input type="checkbox"/>	At Home <input type="checkbox"/>
Emotional/psychological support <input type="checkbox"/>	Hospital assessment <input type="checkbox"/>	In Hospital (see over) <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Day Care <input type="checkbox"/>	Other e.g. Nursing Home <input type="checkbox"/>
Assessment for hospice admission..... <input type="checkbox"/>	Outpatient service <input type="checkbox"/>	Please specify
Carer support <input type="checkbox"/>	Admission (<i>delete</i>). <input type="checkbox"/>	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other reason (please give details below). <input type="checkbox"/>	Respite / symptom control / terminal care	
Main carer for wife who had cva last year and not coping	Hospice at Home <input type="checkbox"/>	

Any access issues (e.g. key safe):		
MRSA Status Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/>	Any other communicable infection:	
Special device in situ? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give details (e.g. trache / PEG / ICD / NIPPV):		
Referrer's Name:	Contact number:	Bleep no:
Hospital/Surgery:	This information required on both pages if faxing	

IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/>
IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE



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 <input type="checkbox"/> No <input type="checkbox"/>	

Brief History of diagnosis(es) and Key treatments		
Date		

Current palliative care problems	
1.	4.
2.	5.
3.	6.
Patient Mobility:	Bariatric Nursing required? Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Referrer's expectation of current treatment 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 or Health Analytics? 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 <input type="checkbox"/> No <input type="checkbox"/>
		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:	
Job title:	Contact number:	Bleep no:
Surgery or Hospital:	Date:	