|  |
| --- |
| **ASHGATE HOSPICE OCCUPATIONAL THERAPY TEAM** |
| **Please tick to indicate the priority of this referral:**Occupational Therapy service operates Mon-Fri 9.00am – 17.00pm**EMERGENCY** (within 4hrs)[ ]  **URGENT** (within 48hrs working days) [ ]  **DETERIORATING** (within 5 working days) [ ]  **ROUTINE (within** 10 days) [ ] **If the referral is EMERGENCY OR URGENT, please state reason why:** (Please see **Referral Criteria** for further information) |
| **GUIDANCE: Please complete all relevant sections below. Please email completed form and relevant documentation to:** ashgatecnstriage@nhs.net **Clinical Admin Team and weekend contact Tel: 01246 565026 9.00am – 17.00pm****REFERRALS WILL NOT BE ACCEPTED IF INFORMATION REQUESTED IS NOT COMPLETED OR IF THE PATIENT REFUSES TO CONSENT** |
| **Date of referral:** | **Name of referrer:** **Job Title:** | **Base of Work:** |
| **Email:** | **Contact telephone:** |
| **Base of work:** |
| **HAS THE PATIENT CONSENTED TO THE REFERRAL AND AGREED TO SHARING THEIR HEALTH RECORDS?****YES** [ ]  **NO** [ ]  |
| **Is the District Nursing team involved in the patients care?****YES** [ ]  **NO** [ ] If No, please make a referral to the District Nursing Team |
| **Has the patient been previously known to Ashgate Hospice?****YES** [ ]  **NO** [ ]  |
| **What is the patients current location:** |
| **PATIENT DETAILS** |
| **Name of patient:**  |  |
| **NHS number:** | **Date of birth:** | **Age:** |
| **Address:** |
| **Contact Tel:** | **Mob:** |
| **Is English their first language? YES** [ ]  **NO** [ ] **If NO, what is their preferred language:** **Ethnicity:****Marital status:** | **Does the patient live alone? YES** [ ]  **NO** [ ] **Key safe:****Religion:** |
| **NEXT OF KIN/PREFERRED CONTACT** | **OTHER RELEVANT FAMILY MEMBER** |
| **Name:****Relationship:****Address:****Contact Tel:****Mob:** | **Name:****Relationship:****Address:****Contact Tel:****Mob:** |
| **GP AND DISTRICT NURSE TEAM** |
| **Named GP:****Surgery:****Tel:****Is GP aware of referral?**  YES [ ]  NO [ ]  | **District Nurse:****Tel:**Please refer to district nursing team if not already under their care. |
| **OTHER PROFESSIONALS INVOLVED** |
| **Name of Hospital Consultant:** **Base:** **Contact no:** | **Additional professions if known:****Base:****Contact no:** |
| **Palliative Care Consultant/CNS:** | **Social Services involved: Yes** [ ]  **No** [ ]  **Unknown** [ ] **Care Manager:** |

|  |
| --- |
| **DIAGNOSIS, TREATMEMNT AND PAST MEDICAL HISTORY:** |
| **Primary Diagnosis:****Date of Diagnosis** |
| **Metastases:****Date of Diagnosis:** |
| **Past Medical History:** |
| **PLEASE STATE DETAILED REASON FOR REFERRAL INCLUDING CURRENT SYMPTOMS AND FUNCTIONAL DIFFICULTIES:** |
| **EQUIPMENT ALREADY IN THE HOME (PLEASE STATE):**  |
| **Is the patient currently having any treatment/investigations?** |
| **Does the patient have any mobility, disability, communication, or language issues?** |
| **Has a DS1500 been completed? YES** [ ]  **NO** [ ]  **UNKOWN** [ ]  |
| **HOME RISK ASSESSMENT** |
| **Are there any Hazards in the home?****YES** [ ]  **NO** [ ]  **UNKNOWN** [ ] **If YES please state:****Are there any pets in the home?****YES** [ ]  **NO** [ ]  **UNKNOWN** [ ] **If YES please state:** | **Are there any smokers in the home?****YES** [ ]  **NO** [ ]  **UNKNOWN** [ ] **Any past episodes of aggression or violence?****YES** [ ]  **NO** [ ]  **UNKNOWN** [ ] **Are their any difficult family circumstances?****YES** [ ]  **NO** [ ]  **UNKNOWN** [ ] **If YES please provide more information:** |
| **DOCUMENTATION** |
| **Please tick which documentation you have included with the referral:****List of current medication** [ ]  **Latest clinic letter** [ ]  **Latest letter from GP** [ ] **GP Summary Past Medical History** [ ]  **DS1500 Form** [ ]  **Relevant investigation and results** [ ] **PLEASE NOTE THAT YOU MUST INCLUDE A CURRENT LIST OF MEDICATION AND AT LEAST ONE MORE OF THE ABOVE DOCUMENTATION WITH THE REFERRAL TO BE ACCEPTED AND AVOID DELAY.** |