

**ASHGATE HOSPICE PALLIATIVE CARE SPECIALIST NURSE TEAM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please tick whether this is an Unstable or a Deteriorating referral to the hospice:  **UNSTABLE** (0-2 working days)  **DETERIORATING** (3-10 days)  Please note If the referral is STABLE or does not meet the referral criteria, it may not be accepted by the Palliative Care Nurse Specialist Team, and either be discharged to their primary care team and/or signposted to another hospice service for ongoing support and management. Please see criteria for further information. | | | | | | | |
| **GUIDANCE: Please complete all relevant sections below. Please email completed form and relevant documentation to:** [ashgatecnstriage@nhs.net](mailto: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:** | | | |
| **Referrer’s availability to be contacted:** | | | | | | | |
| **HAS THE PATIENT CONSENTED TO THE REFERRAL AND AGREED TO SHARE THEIR HEALTH RECORDS?**  **YES  NO** | | | | | | | |
| **Is the District Nurse involved in the patient’s care? Yes  No**  If no, please make a referral to the District Nursing Team. | | | | | | | |
| **Has the patient been known previously to Ashgate Hospice? Yes  No**  If yes, please state which services: | | | | | | | |
| **Patient’s current location:** | | | | | | | |
| **PATIENT DETAILS** | | | | | | | |
| **Name of patient** |  | | | | | | |
| **NHS number:** | | | **Date of birth:** | | | | **Age:** |
| **Address:** | | | | | | | |
| **Contact Tel:** | | | | | **Mobile:** | | |
| **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 NURSING TEAM** | | | | | | | |
| **Named GP:**  **Surgery:**  **Tel:**  **Is GP aware if referral? Yes  No** | | | | | **District Nurse:**  **Tel:**  Please refer to the District Nursing Team if you have not already done so. | | |
| **OTHER PROFESSIONALS INVOLVED** | | | | | | | |
| **Name of Hospital Consultant:**  **Base:**  **Contact Tel:** | | | | **Additional Professional if known:**  **Base:**  **Contact Tel:** | | | |
| **Palliative Care Consultant/CNS:** | | | | **Social Services involved?**  **Care Manager:** | | | |

|  |  |  |
| --- | --- | --- |
| **DIAGNOSIS, TREATMENT AND PAST MEDICAL HISTORY** | | |
| **Primary(ies) Diagnosis:**  **Date of Diagnosis:** | | |
| **Metastases:**  **Date of Diagnosis:** | | |
| **Past Medical History:**  **Allergies: Yes  No  Unknown  If yes, please state:** | | |
| **PLEASE STATE DETAILED REASON FOR REFERRAL INCLUDING CURRENT SYMPTOMS:** | | |
| **Is the patient currently having any treatment/investigations?** | | |
| **Does the patient have any mobility, disability, communication/language issues?** | | |
| **Has a DS1500 been completed?**  **Yes  No  Unknown** | | |
| **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/violence?**  **Yes  No  Unknown**  **Are there 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**  **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.** | | |
| **Date of discharge** | **Date/Place of death** | |
|  |  | |