RM Partners
Accountable Cancer Network

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

NHS

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

Greenwich & Bexley Community Hospice Bostall Hill, Abbey Wood **SE2 0GB** Assessment Coordination Team Tel: 020 8320 5837 **Email:** gbch.referrals@nhs.net	**Lewisham Macmillan Community Team:** Lewisham High Street **SE13 6LH** Tel: 020 8333 3017 Fax: 020 8333 3270 **Email:** LG.UHLPalliativeCareTeam@nhs.net	**St Christopher's Hospice** Lawrie Park Rd, London **SE26 6DZ** Referral & Admissions: Tel. 020 87684582 Fax: 02086595051 **Email:** stc.referral@nhs.net
Guy's & St Thomas' Community Team: Guy's Hospital, Great Maze Pond **SE1 9RT** Tel: 020 71884754 Fax: 020 71884748 **Email:** gst-tr.gstt-palliativecare@nhs.net	**Meadow House Hospice** Southall **UB1 3HW** Tel: 020 89675179 Fax 020 89675756 **Email:** referralsmeadowhouse@nhs.net	**St John's Hospice** Grove End Road, St John's Wood **NW8 9NH** Tel:020 78064040 Fax: 020 78064041 **Email:** Clccg.stjohnsreferrals@nhs.net
Harlington Hospice St Peter's Way, Harlington **UB3 5AB** Tel: 020 87590453 Fax: 020 87590600 **Email:** HILLCCG.harlingtonhospicereferrals@nhs.net	**Michael Sobell House** Northwood, Middlesex **HA6 2RN** Tel: 020 38262373 Fax: 020 38262387 OOH / Inpatient unit: 020 38262377 Referrals mob: 07900 228036 **Email:** msh.enh-tr@nhs.net	**St Luke's Hospice** Kenton Road, Harrow **HA3 0YG** Tel: 020 83828000 Fax: 020 83828080 Community Team Fax: 020 83828092 **Email:** LNWH-tr.referralsstlukes@nhs.net
Harrow Community Team Kenton Road, Harrow **HA3 0YG** Tel: 020 83828084 Fax: 020 83828085 **Email:** LNWH-tr.HarrowcommunitySPCT@nhs.net	**Pembridge Palliative Care Centre** Exmoor Street, **W10 6DZ** Tel: 020 8102 5000 Inpatient E-Fax: 03000083207 Comm. Services E- Fax: 0300 008 3206 **Email:** CLCHT.PembridgeUnit@nhs.net	**St Raphael's Hospice** London Road, North Cheam **SM3 9DX** Tel: 020 80997777 Fax: 020 8099 1724 **Sutton CCG referrals to go to:** sutccg.raphaelshospicereferrals@nhs.net **Merton CCG referrals to go to:** merccg.raphaelshospicereferrals@nhs.net
Hillingdon Community Team Pield Heath Road, Uxbridge **UB8 3NN** Tel:01895 279412 Fax: 01895 279452 **Email:** thh-tr.pallcare@nhs.net	**Princess Alice Hospice** West End Lane, Esher **KT10 8NA** Tel: 01372 461804 Fax: 01372 470937 **Email:** SDCCG.clinicaladminpah@nhs.net	**Royal Trinity Hospice** Clapham Common **SW4 0RN** Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065 Fax: 020 7787 1067 **Email:** rth.referrals@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	

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**

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Essential Patient Details		
Surname	Male☐ Female☐ Age:	Patient consent to palliative care involvement? Yes ☐ No ☐ Best interest ☐
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	
	Continuing care assessment completed: ○ **Yes** ○ **No** **Continuing care funding agreed:** ◉ **Yes** ○ **No**	CCG:

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 Positive ☐ Negative ☐ Not known ☐	**Any other communicable infection:**
Special device in situ? Yes ☐ No ☐ 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 ☐ No ☐

IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

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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, 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? 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:**
Job title:	**Contact number:** **Bleep no:**
Surgery or Hospital:	**Date:**