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| **Please attach relevant additional correspondence, results and/or summary care record/discharge summary and email to** Bhccg.martlets-singlepointofaccess@nhs.net **with the completed referral form. Failure to send this information may delay the patient’s initial assessment.** **If your referral is urgent please also contact us on 01273 964164 once the documentation has been submitted.** |
| **Patient Name:** **Address:** **Postcode:** **Phone Number:** **Current Location:**  | **DoB:** **NHS Number:** **Lives alone: Yes □ No □** | **GP Name****Practice Address:****Phone Number:** |
| **Has the patient consented to referral? Yes □ No □** **If patient lacks capacity to consent is the referral being made in their best interest? □****If yes:****Date of Mental Capacity Assessment:****Mental Capacity Assessment completed by:** | **Next of kin name:****Title:** **Relationship to patient:****Phone number:** **Address:****Postcode:** |
| **Diagnosis, including details of disease and treatment history:****Please attach current medication and indicate any known allergies:**  | **DNACPR in place: Yes □ No □****ReSPECT in place: Yes □ No □ DS1500 completed: Yes □ No □** |
| **Phase of Illness (urgency of the plan of care to address the needs of the patient and family). Please tick the relevant box:** |
|  | **Dying** | **Death is likely within days** |
|  | **Deteriorating**  | **Patient’s overall functional status is declining, and the patient experiences a worsening of existing problem(s) and/or a new, but anticipated problem** |
|  | **Unstable** | **An urgent change in the plan of care is required because the patient experiences a new problem or a rapid increase in the severity of a current problem** |
|  | **Stable** | **Problems and symptoms are adequately controlled by established plan of care, family/carer situation is relatively stable and no new issues are apparent** |
| **Australian Karnofsky Performance Status (AKPS), please tick the relevant box** |  | **30% almost completely bedfast** |  | **70% self-caring but unable to work/carry out normal activity** |
|  | **40% in bed > 50% of the time** |  | **80% normal activity with effort, some symptoms** |
|  | **10% Comatose** |  | **50% considerable assistance, frequent medical care required** |  | **90% normal activity, minor symptoms** |
|  | **20% Totally bedfast** |  | **60% occasional assistance required** |  | **100% normal** |
| **Main issues:****1.****2.****3.****Please provide further relevant details about your patient and why you are referring to specialist palliative care or supportive services:****Have any risks been identified regarding this patient or their home? (if yes provide details) Yes □ No □** |
| **Referrers Name:** **Job Title:** | **Contact details:** **Date:**  |