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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](mailto: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:** | | | |