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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 ALL RELEVANT INFORMATION MAY DELAY THE PATIENT’S 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:** **Date of birth:****NHS number:**  | **Lives alone: Yes □ No □****Current location:****Has the patient got any mobility issues?** (if yes, please describe) **Yes □ No □****Have any risks been identified regarding this patient or their home?** (if yes, provide details) **Yes □ No □**  |
| **GP Name:****Practice Address:****Phone Number:** | **Next of kin name:****Title:** **Relationship to patient:****Phone number:** **Address:****Postcode:** |
| **Has the patient consented to referral? Yes □ No □****If patient lacks capacity to consent:**Date of Mental Capacity Assessment: Mental Capacity Assessment completed by: | **DNACPR in place: Yes □ No □****ReSPECT in place: Yes □ No □** **DS1500 completed: Yes □ No □** |
| **Which service are you referring to?** **Community Palliative Care Team Assessment □ Hospice In-Patient Unit Admission □** |
| **Diagnosis, including details of disease and treatment history:****Main issues:****1.****2.****3.****Please attach current medication and indicate any known allergies** |
| **REQUESTED PRIORITY FOR ASSESSMENT:** **□ Death likely within days – needs urgent assessment within 24 hours****□ Rapid increase in severity of symptoms – needs urgent assessment within 24 hours****□ Declining functional status and gradual worsening of symptoms – needs routine assessment within 72 hours** |
| **AUSTRALIAN KARNOFSKY PERFORMANCE STATUS (AKPS):****□ 10% Comatose** **□ 20% Totally bedfast and needing extensive nursing care by professionals/family** **□ 30% Almost completely bedfast** **□ 40% In bed > 50% of the time** **□ 50% Considerable assistance and frequent medical care required** **□ 60% Able to care for most needs but occasional assistance required** **□ 70% Self-caring but unable to work/carry out normal activity** **□ 80% Normal activity with effort, some symptoms of disease** **□ 90% Normal activity, minor symptoms of disease** **□ 100% Normal, no complaints or evidence of disease** |
| **Referrer’s name:** **Job title:** | **Contact details:**  | **Date:** |