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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 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:** |