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| **Please attach relevant additional correspondence, results and/or summary care record/discharge summary and email to** [Sxicb-bh.martlets-singlepointofaccess@nhs.net](mailto:Sxicb-bh.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:**  **Home Address:**  **Postcode:**  **Phone number:**  **Date of birth:**  **NHS number:** | | **Lives alone:  Yes  No**  **Current location:  Home  Other**  (if other, please describe)  **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:** |