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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 **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:** |