



REFERRAL FORM

St. Joseph's Hospice
Mare Street, London E8 4SA

Fax: 020 8525 6085
Tel: 020 8525 6000
Email: referrals@stjh.org.uk

OFFICE USE
Ref No.....
Hos No.....
Date rec.....
Date acc.....
Acc by.....

PATIENT DETAILS:

Surname:..... Title.....	M / S / W / D	Male / Female
First Names.....	Age:.....	DoB:.....
Address:	Occupation:.....	
.....	Ethnicity:.....	
.....	Religion:.....	
Postcode:	English speaking? <input type="checkbox"/> yes <input type="checkbox"/> partial <input type="checkbox"/> no	
Telephone:	Main language.....	
Mobile phone:.....	Interpreter's Details.....	
HOSPITAL NO.....NHS NO:		

PATIENT INFORMATION:

Diagnosis (AND histology)	Date of Diagnosis
Metastases:.....	
Estimated Prognosis: <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> >6 months	
Mobility: <input type="checkbox"/> Independent <input type="checkbox"/> Needs assisting <input type="checkbox"/> Mostly bedbound <input type="checkbox"/> Paraplegic	
MRSA status:	(any other infections.....)
Any special nursing needs.....	
Is the patient aware of this referral?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the patient aware of the diagnosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has prognosis been discussed with the patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has CPR been discussed with the patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, status.....)
Where is the patient at present?	
<input type="checkbox"/> At home, does the patient live alone?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of any risk to staff visiting this patient in their home?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please give any relevant details:.....	
<input type="checkbox"/> In hospital: Name of hospital..... Ward..... Tel.....	
<input type="checkbox"/> Elsewhere, eg nursing home (give address, if different to home address)	
The patient's preferred place of care (if known).....	

REASONS FOR REFERRAL:

REFERRAL TO: (please circle)	Inpatient Team	Community Team	Day Hospice
REFERRAL FOR: (please circle)	Symptom Control	Respite	Rehabilitation/longer stay Terminal Care

PATIENT'S NAME _____ DATE OF BIRTH _____

patients with exceptional specialist palliative care needs	
Any comments.....	
CONTACT DETAILS:	
GP Name..... Address..... Postcode:..... Tel..... Fax..... PCT..... Is GP aware of referral?..... Is patient on the GP palliative care register?.....	FURTHER HOSPITAL DETAILS Consultant most recently in charge..... Contact for Consultant..... Is the Consultant aware of this referral?..... HOSPITAL PALLIATIVE CARE TEAM (if involved) Name of Contact..... Tel..... Fax..... Is the Hospital PC team aware of referral?.....
MAIN CARER Name..... Address..... Postcode:..... Tel..... Relationship to patient.....	NEXT OF KIN (if known) Name..... Address..... Postcode:..... Relationship to patient.....
DISTRICT NURSE (essential for referral to community team) Name..... Address..... Postcode:..... Tel..... Fax..... PCT.....	LASTING POWER OF ATTORNEY (person legally appointed by the patient to make healthcare decisions on their behalf) Name..... Date appointed..... Address..... Postcode:..... Tel.....
SOCIAL WORKER (if applicable) Name..... Address..... Postcode:..... Tel..... Fax..... Has a Continuing Care Assessment been completed? ♦ YES ♦ NO If yes: ♦ PCT Funded (name.....) ♦ Social Services ♦ Joint Funding Details of care package.....	ANY OTHER KEY PROFESSIONALS INVOLVED (eg CPN, physio, dietitian, colostomy nurse, pain team) Name..... Role..... Tel..... Name..... Role..... Tel.....

PATIENT'S NAME _____ DATE OF BIRTH _____

CLINICAL DETAILS:

HISTORY OF ILLNESS, TREATMENTS, PAST MEDICAL (AND PSYCHIATRIC) HISTORY *(chronologically)*

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MEDICATIONS *(name, dose, frequency)*
or send us an up-to-date computer print-out

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ALLERGIES: *(please describe)*

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MAIN PROBLEMS AND SYMPTOMS *(please also comment on level of mobility, feeding needs, use of oxygen and any particular concerns of the patient or family and any other information you think will help)*

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REFERRED BY:

Name..... Title.....

Date of Referral..... Contact

Details.....

NB Please read this: *It is essential that you also fax or attach a photocopy of a recent medical summary (which describes diagnosis, histology, treatments, medication changes) AND recent clinic letters and recent blood results. Please feel free to phone us if it would help (Tel 020 8525 6000 - and ask to speak with the referral team). Thank you for all the time you have taken to convey all this information – it greatly improves the patient’s experience of referral.*

GUIDELINES FOR REFERRAL TO ST. JOSEPH'S HOSPICE

How To Make A Referral

Referrals can be made by any professional who knows the patient, or by the patient or their family subject to the agreement of their GP.

Referrals should be made on the hospice referral form available from the hospice website www.stjh.org.uk or via the Referral and Admissions Office, tel. 020 8525 6067, fax. 020 8525 6085. When complete, they should be sent to the Referral and Admissions Office marked for the attention of the Referrals Team.

The patient should be aware of the referral and agreeable to it.

- If the referrer is not the GP, it is recommended that the GP is alerted to the referral in advance of it being sent to the hospice. St Joseph's requires the agreement of the patient's GP prior to being able to visit patients in the community setting.
- Referrals should be accompanied by relevant medical and treatment information to enable hospice personnel to assess the appropriateness of the referral and plan their initial assessment. This information is likely to include a medical summary, copies of investigations confirming diagnosis and prognosis (where estimated) and medication on referral. In the event that the patient is in hospital, the referrer or a nominated individual needs to contact the Referral and Admissions Office to notify them of the actual date of discharge.
- In the event that the patient's condition changes or they change their mind about referral to the hospice, the referrer is requested to contact the Referral and Admissions Office to alert the hospice of the change.
- To discuss eligibility criteria and whether an individual or their family is likely to benefit from hospice support referrers are invited to speak to the Referral and Triage Clinical Nurse Specialist by phoning the hospice 020 8525 6000 bleep 47, who will refer to other professionals as necessary.

Referrer Expectations Of The Hospice

Referrers can expect:

Patients to be offered a bed in the hospice within 3 working days of the receipt of the referral and accompanying information, or notification of the reasons for the delay and revised estimation of the period during which a bed is likely to be offered to the patient.

Written notification of the proposed plan for admission/assessment for community based care including day hospice within 4 working days of receipt of the referral.

The Referrals and Triage Clinical Nurse Specialist to make contact with the patient referred for support in the community within 2 working days of receipt of referral to assess the urgency of the referral and any immediate problems which need to be addressed.

Assessment of a patient referred to the community palliative care team within 10 working days of the receipt of referral or earlier depending on the urgency of the referral.

To be notified of the outcome of a community assessment by a member of the community palliative care team within 2 working days of the assessment.

For further information about the Referral and Admissions Team please phone 020 8525 6067 or email referrals@stjh.org.uk

St. Joseph's Hospice
Mare Street
Hackney
London E8 4SA
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Fax: 020 8533 0513

