NHS East Suffolk and North Essex NHS Foundation Trust

St Helena

your local healthcare provider ace anglian community enterprise

COMMUNITY PALLIATIVE CARE REFERRAL FORM

This referral form is used as a single point of access to services for patients within the last year of their life and/or complex specialist palliative care needs. This form needs only to be submitted once, and will encompass all services listed below. Please do not submit any additional referrals for this patient to other services that are included on this form.

Referral Source		
Date of referral:	Time:	Hospital / Community
Referrer's Name	Job Title:	
Contact Tel:	Secure Email:	

Can tick multiple boxes
☐ Referral to community end of life team for pain/symptom control, emotional/psychosocial/spiritual, other (please specify)_____
☐ Referral for specialist palliative care where the patient has complex needs, with a prognosis of more than a year and a confirmed life limiting diagnosis.
☐ Referral for care at home for last 6 weeks of life – Has a TNA (Trusted Needs Assessment) been completed? Yes ◯ No ◯
☐ Request for inpatient hospice bed (N/B – ESNEFT patients via Palliative care team only)
☐ Request for District Nurse/Community ANP (Matron) visit for e.g. catheter care, wound dressings for all patients in the last year of life

Urgency	
If you mark the referral as non-urgent it will be dealt with the next working day Urgent referrals need to be followed up by a phone call to SinglePoint (01206 890360)	Urgent ◯ Non-urgent ◯

Patient Details			
NHS Number:		DOB:	
Title:	First Name:	Last Name:	
Home Tel:		Mobile Tel:	
Address:			Post Code:
NOK Name:		NOK Tel / email:	
Diagnosis			
Previous medical history			
What is patients understanding of their condition and prognosis?			

Is the patient aware of diagnosis?	Yes ◯ No ◯
Has the patient consented to this referral?	Yes ◯ No ◯ Is there a best interest decision in place? Details : Has the patient's electronic record been shared ie SystmOne? Yes ◯ No ◯
Virtual Consultation	Does the patient have access to a smartphone or computer to allow virtual consultation? Yes ◯ No ◯
Advance Care Planning	DNACPR completed: Yes ◯ No ◯ Is this decision indefinite: Yes ◯ No ◯ ReSPECT form completed: Yes ◯ No ◯ Is the patient already known to a PCN: Yes ◯ No ◯ Who is the allocated keyworker:
Reason for referral and on-going plan of care for the patient	
Respiratory	Is the patient receiving any of the following? Oxygen: Yes ◯ No ◯ CPAP: Yes ◯ No ◯ NIVI: Yes ◯ No ◯ Does the patient require suctioning: Yes ◯ No ◯
Vulnerabilities/specific needs	Please tick any that apply: Learning disability ☐ Dementia ☐ Cognitive impairment ☐ Significant mental health ☐ physical impairment ☐ Sensory impairment ☐ communication difficulties ☐ Please state e.g. deaf, blind, visually impaired, other
Community Services **DN/Matron**	Date first visit required from District Nurses : Has the patient recently had : reduced mobility ☐ reduced appetite ☐ increased falls ☐ increased infections ☐ Braden score : Must score : Wound/pressure sore sites : Is the patient IDDM? Yes ◯ No ◯ If yes has their insulin regime recently been reviewed? Yes ◯ No ◯ Is the patient on a syringe pump? Yes ◯ No ◯ Have you put the DN authorisation form in the yellow folder? Yes ◯ No ◯ If no, where is it?

Infection Status / Covid-19	COVID Positive ◯ Negative ◯ Date: MRSA: Positive ◯ Negative ◯ Date: OTHER:
Referrals should be sent to: Shh.singlepoint@nhs.net	