St Giles Hospice Care

Whittington:
Telephone : 0300 330 9410
Fax : 01543 434560
Email : stgilesclinical@nhs.net

Walsall:
Telephone : 01922 602525
Fax : 01922 602541
Email : stgiles.walsallipu@nhs.net

St Giles Hospice Care Walsall

Hospice at Home Referral Form

Patient Details:							
Patient Name:					**Title**		
Patient NHS Number:					**Date of Birth:**		
Address:							
Post Code:							
Telephone Number:	Home:				Mobile:		
Marital Status:					Gender:		
Ethnicity:					Religion:		
Patient aware of:	Referral	Yes ☐ No ☐	Diagnosis	Yes ☐ No ☐	Prognosis	Yes ☐ No ☐	
Carer aware of:	Referral	Yes ☐ No ☐	Diagnosis	Yes ☐ No ☐	Prognosis	Yes ☐ No ☐	
DN aware of:	Referral	Yes ☐ No ☐	Are DN notes in the home?		Yes ☐ No ☐ N/a ☐		
Location of patient at point of referral:	Own Home	☐			Residential / Nursing Home	☐	
	Hospital				Ward		
	Planned discharge date:						
Is patient known to Hospice?		Yes ☐ No ☐					
Has patient consented to referral		Yes ☐ No ☐	If No, please state why				
Diagnosis:							
Other relevant medical problems:							
Known allergies or sensitivities							
Estimated prognosis:	Days ☐	Weeks ☐	Months ☐				
Is there an ACP in place?		Yes ☐ No ☐			Is DNACPR in place?	Yes ☐ No ☐	
Does Patient Have an Advance Decision to Refuse Treatment?					Yes ☐ No ☐		
Carer Details:							
Carer Name:							
Relationship to patient:					Is carer next of kin?	Yes ☐ No ☐	
Address:					Post Code:		
Telephone Number:	Home:				Mobile:		
Preferred Priorities:	Care:				Death:		
NOK contact details:							
Reason for initial referral:	☐ End of life care				☐ Personal care		
	☐ Respite care (dependent upon capacity of service)						
	☐ Post discharge care				From where?		
Visits required:	☐ Day ☐ Evening ☐ Night						
GP Details:							
GP name:							
Address:							
Post Code:					Tel No:		
Supporting agencies:	☐ District Nurse		Details:				
	☐ Palliative Care Nurse		Details:				
	☐ CHCC / DLN		Details:				
	☐ Community Matron		Details:				
	☐ Social Services		Details:				
	☐ Marie Curie		Details:				
	☐ Care Agency		Details:				
	☐ Other:		Details:				

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Access to property (inc. parking, poor lighting)	
Type of dwelling	☐ House ☐ Flat ☐ Bungalow ☐ Rest Home ☐ Other:
Key code / Safe number:	
Potential Hazard / Risks (Aggressive behaviour, pets, smoky environment, family)	Any capacity issues? Yes ☐ No ☐ Any safeguarding issues? Yes ☐ No ☐
Summary of patient's condition (current problems needs)	
Breathing difficulties (e.g. increased secretions, dyspnoea)	Oxygen: Yes ☐ No ☐ Current Smoker: Yes ☐ No ☐
Communication (e.g. hearing, vision, speech, cognitive state)	Conscious level: ☐ Alert ☐ Semi-conscious ☐ Comatose First language if not English | Interpreter required? Yes ☐ No ☐
Nutrition (e.g. diet, fluid restrictions, swallowing ability)	Is the patient able to swallow anything? Yes ☐ No ☐ History of diabetes? Yes ☐ No ☐
Mobility (e.g. moving and handing risks, history of falls)	Slide sheet present Yes ☐ No ☐ Is the patient hoisted Yes ☐ No ☐
Continence (e.g. bowel / bladder weakness)	Continence pads available Yes ☐ No ☐
Sleep disturbance (e.g. terminal agitation, restlessness)	Hospital bed in use Yes ☐ No ☐ Protection rails in use Yes ☐ No ☐
Pain (Sites, current treatment)	Able to swallow tablets Yes ☐ No ☐ Able to swallow liquid medicine Yes ☐ No ☐
Skin condition (e.g. tissue viability, oedema, pressure sores)	Pressure relieving mattress in use Yes ☐ No ☐ Pad in use Yes ☐ No ☐
Personal safety – other needs (e.g. lives alone, main carer unwell, history of confusion, known palliative care emergency)	Pendant / call alarm available and in use Yes ☐ No ☐
Current medication	Dosset pack in use Yes ☐ No ☐ Anticipatory drugs in home Yes ☐ No ☐ Syringe driver in use Yes ☐ No ☐ Pacemaker Yes ☐ No ☐ ICD Yes ☐ No ☐

Referrer's Name		Signature	
Job Title		Contact / Bleep No:	
Health Centre / Surgery or Hospital		Date:	