Confidential Referral Form

Each referral will receive a multi-disciplinary discussion to determine which service is the most appropriate based on the information supplied. St Catherine's utilises a triaging tool, from which this referral form is based.

Insufficient information may result in delays, the referral form returned pending additional information or your patient's assessment being delayed, due to being triaged as a lower priority level. Please complete this form in full indicating which service you are requesting

Please note that community referrals can only be accepted for people who are registered with a General Practitioner (GP) in Chorley, Greater Preston, Longridge, or South Ribble. If a person referred to the inpatient unit is not registered with a GP in Chorley, Greater Preston, Longridge, or South Ribble, please contact the hospice on 01772 629171 (Monday to Friday 08.30-16.30) to discuss with a member of the medical team prior to submitting a referral.

Please email complete referrals to stch.clinical.admin@nhs.net

Service Requested

(Please refer to St Catherine's Hospice referral criteria)

☐ Hospice Inpatient unit admission ☐ Community palliative care assessment

Patient Details

Name: Mr Mrs Miss Other - Please specify Gender: Address: Postcode: Contact number: Home: Mobile:	Date of birth: NHS No: Ethnicity: Religion: Primary language: Does the patient live alone? Y / N Does the patient have any dependants? Y / N

Next of Kin details	Main Carer details (if different):
Name:	Name:
Relationship to patient:	Relationship to patient:
Address:	Address:
Postcode:	Postcode:
Contact number:	Contact number:
Date of birth:	Date of birth:
Aware of referral?: Y / N	Aware of referral?: Y / N

Consent

Please select one option

The patient has capacity and consents to this referral	
The patient does not have the capacity to consent to this referral therefore the referral has been made in their best interests	

Details of Illness

(please attach all relevant information e.g. letters, annotations, medications list)

Primary Diagnosis including dates:
Treatment history including recent relevant investigations:
Relevant Medical History and Co-morbidities:
Previous and current medications/interventions. Include current medication list:

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Reasons for Referral

please complete fully as this information support triage and timely assessment of your patient

Physical symptoms or distress – details:
Psychological or spiritual distress – details:
Family/Caregiver distress or concern – details:
Current care arrangements and any concerns – details: Is the patient currently in receipt of: Continuing health care Y / N A care package Y / N
Advance Care Planning/EPaCCs information Resuscitation status: Is there a uDNACPR form in place. Y / N and detail PPC: PPD: LPA health and welfare: LPA property and finance: GSF status – Green, Amber, Red Anticipatory medications in place. Y / N and detail

Is Patient Known to District Nurses

(For community palliative care assessment)

Yes	
No	

If no please ensure referral to the district nursing service is made at the time of referral

Current Risk / Specific Information

Are there any identified risks posed to health professionals e.g. acts of threats of violence, pets, etc	Yes (Include details)	No
The patient (e.g Mobility Issues, Infections, Safeguarding, Pressure Ulcers, Wounds, Dietary Requirements, Plus size):	Yes (Include details)	No
Deprivation of liberty safeguards in place?	Yes (Include details)	No

Details Of Professionals / Teams Currently Involved

Name	Profession	Contact number

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Referrer Details

Name:

Profession:

Address:

Contact No:

Patient GP and practice (if GP not the referrer):
Contact No:

If not GP, is the GP aware of the referral:

Date of Referral:

Help us to prioritise your Referral

Please provide all the information requested - Thank you