

Specialist Palliative Care Community Teams & Inpatient Units across South & West London

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| <input type="checkbox"/> Greenwich & Bexley Community Hospice Bostall Hill, Abbey Wood SE2 0GB Assessment Coordination Team Tel: 020 8320 5837 Email: gbch.referrals@nhs.net | <input type="checkbox"/> Lewisham Macmillan Community Team: Lewisham High Street SE13 6LH Tel: 020 8333 3017 Fax: 020 8333 3270 Email: LG.UHLPalliativeCareTeam@nhs.net | <input type="checkbox"/> St Christopher's Hospice Lawrie Park Rd, London SE26 6DZ Referral & Admissions Tel: 020 87684582 Fax: 020 8659 5051 Email: stc.referral@nhs.net |
| <input type="checkbox"/> Guy's & St Thomas' Community Team: Guy's Hospital, Great Maze Pond SE1 9RT Tel: 020 7188 4754 Fax: 020 7188 4748 Email: gst-tr.gstt-palliativecare@nhs.net | <input type="checkbox"/> Meadow House Hospice Southall UB1 3HW Tel: 020 8967 5179 Fax 020 8967 5756 Email: referralsmeadowhouse@nhs.net | <input type="checkbox"/> St John's Hospice Grove End Road, St John's Wood NW8 9NH Tel: 020 7806 4040 Fax: 020 7806 4041 Email: Clccg.stjohnsreferrals@nhs.net |
| <input type="checkbox"/> Harlington Hospice St Peter's Way, Harlington UB3 5AB Tel: 020 8759 0453 Fax: 020 8759 0600 Email: HILLCCG.harlingtonhospicereferrals@nhs.net | <input type="checkbox"/> Michael Sobell House Northwood, Middlesex HA6 2RN Tel: 020 3826 2373/2374 OOH / Inpatient unit: 020 3826 2377 Referrals mob: 07900 228036 Email: msh.enh-tr@nhs.net | <input type="checkbox"/> St Luke's Hospice Kenton Road, Harrow HA3 0YG Tel: 020 8382 8000 Fax: 020 8382 8080 Community Team Fax: 020 8382 8092 Email: LNWH-tr.referralsstlukes@nhs.net |
| <input type="checkbox"/> Harrow Community Team Kenton Road, Harrow HA3 0YG Tel: 020 8382 8084 Fax: 020 8382 8085 Email: LNWH-tr.HarrowcommunitySPCT@nhs.net | <input type="checkbox"/> Pembroke Palliative Care Centre Exmoor Street, W10 6DZ Tel: 020 8102 5000 Inpatient E-Fax: 03000083207 Comm. Services E- Fax: 0300 008 3206 Email: CLCHT.PembrokeUnit@nhs.net | <input type="checkbox"/> St Raphael's Hospice London Road, North Cheam SM3 9DX Tel: 020 8099 7777 Fax: 020 8099 1724 Sutton CCG referrals to go to: sutccg.raphaelshospicereferrals@nhs.net Merton CCG referrals to go to: merccg.raphaelshospicereferrals@nhs.net |
| <input type="checkbox"/> Hillingdon Community Palliative Care Team Pield Heath Road, Uxbridge UB8 3NN Tel: 01895 485235 Email: cnw-tr.hchcontactcentrerefs@nhs.net | <input type="checkbox"/> Princess Alice Hospice West End Lane, Esher KT10 8NA Tel: 01372 461804 Fax: 01372 470937 Email: SDCCG.clinicaladminpah@nhs.net | <input type="checkbox"/> Royal Trinity Hospice Clapham Common SW4 0RN Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065 Fax: 020 7787 1067 Email: rth.referrals@nhs.net |

For further information and advice on these services, please visit the Hospice UK service directory at:
<http://www.hospiceuk.org/about-hospice-care/find-a-hospice> and enter the postcode provided above.

Every hospital has a Specialist Palliative Care team;
if your patient is a *hospital inpatient*, please contact the team, via the relevant hospital switchboard.

FAX MESSAGE

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|---|--------------|
| From: | To: |
| Fax No: | Date: |
| No. of pages (incl. cover sheet): | |
| Additional information | |
| <p>Confidentiality: The content of this fax and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above.</p> | |
| <p>PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM – including recent clinic letters, blood tests and most recent imaging. NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT</p> | |

PATIENT NAME

NHS No.

| Essential Patient Details | | | |
|---------------------------|-------------------------------|---------------------------------|--|
| Surname | Male <input type="checkbox"/> | Female <input type="checkbox"/> | Patient consent to palliative care involvement? Yes <input type="checkbox"/> No <input type="checkbox"/> Best interest <input type="checkbox"/> |
| First Name | DoB | Age: | Is GP aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Address | | | |
| Postcode | Marital Status | Ethnicity | |
| Tel. | Mob. | | |
| NHS number | Hospital No. | | |

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| Primary diagnosis(es) |
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| Communication | Other barriers to communication/registered disabilities: |
| Fluent in English? Yes <input type="checkbox"/> No <input type="checkbox"/> (If 'no' proceed with remaining questions) | |
| First Language, if not English: | |
| Would interpreter be helpful to patient and Palliative Care staff? Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| Next of Kin/Patient Representatives | District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/> | General Practitioner |
|--|--|---|
| Name | Name | Name |
| Address | Based at | Address |
| Postcode | Telephone | |
| Telephone | Fax | |
| Relationship to patient | | Postcode |
| Main Carer (if different from above) | Social Services Yes <input type="checkbox"/> No <input type="checkbox"/> | Telephone |
| Name | Name | Fax/Email |
| Telephone | Based at | CCG: |
| Relationship to patient | Tel | |
| | Fax | |
| | Continuing care assessment completed: Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| | Continuing care funding agreed: Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Reason for Referral | Service requested | The patient is currently |
| Pain/symptom control <input type="checkbox"/> | Home assessment and support. <input type="checkbox"/> | At Home <input type="checkbox"/> |
| Emotional/psychological support <input type="checkbox"/> | Hospital assessment <input type="checkbox"/> | In Hospital (see over) <input type="checkbox"/> |
| Social/financial <input type="checkbox"/> | Day Care <input type="checkbox"/> | Other e.g. Nursing Home <input type="checkbox"/> |
| Assessment for hospice admission..... <input type="checkbox"/> | Outpatient service <input type="checkbox"/> | Please specify |
| Carer support <input type="checkbox"/> | Admission (<i>delete</i>). <input type="checkbox"/> | Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Other reason (please give details below). <input type="checkbox"/> | Respite / symptom control / terminal care Hospice at Home <input type="checkbox"/> | |

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| Any access issues (e.g. key safe): | | |
| MRSA Status | Any other communicable infection: | |
| Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/> | | |
| Special device in situ? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give details (e.g. trache / PEG / ICD / NIPPV): | | |
| Referrer's Name: | Contact number: | Bleep no: |
| Hospital/Surgery: | This information required on both pages if faxing | |

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| <p>IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE</p> |
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|---------------------------|------------------|--|
| In-Patient details | | Patient Name: |
| Hospital | | NHS No: |
| Ward | Direct Ward Ext. | Telephone |
| Key worker | | Date of discharge (if known) |
| Consultant | | Is Palliative Care team involved? Yes <input type="checkbox"/> No <input type="checkbox"/> |

Brief History of diagnosis(es) and Key treatments

| Date | Progression of disease and investigations/treatment | Consultant and hospital |
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Current palliative care problems

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|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Patient Mobility:

Bariatric Nursing required? Yes ☐ No ☐

Any other comments/information (including preferences expressed about care, other psychosocial or spiritual issues or DOLS)

Referrer's expectation of current treatment

symptom control ☐ / life prolonging ☐ / curative ☐

Prognosis: In your opinion, is the patient

Stable? Yes ☐ No ☐

Unstable? Yes ☐ No ☐

Deteriorating? Yes ☐ No ☐

Dying? Yes ☐ No ☐

Is death anticipated within:

Months ☐

Weeks ☐

Days ☐

Patient on Coordinate My Care? Yes ☐ No ☐ Unknown ☐ If not, please give reason

On the GSF register? Yes ☐ No ☐ Unknown ☐

DNACPR in place? Yes ☐ No ☐

Past Medical and Psychiatric History

Current Medication

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Known Drug Sensitivities/Allergies:

Yes ☐ No ☐

Details:

Insight: Has patient been told diagnosis? Yes ☐ No ☐

Is the carer aware of patient's diagnosis? Yes ☐ No ☐

Does patient discuss the illness freely Yes ☐ No ☐

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

| | | | |
|-----------------------|--|-----------------|-----------|
| Referrer's signature: | | Name: | |
| Job title: | | Contact number: | Bleep no: |
| Surgery or Hospital: | | Date: | |