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WESTON HOSPICECARE

**REFERRAL CRITERIA FOR CONSIDERATION OF HOSPICE SERVICES**

**PLEASE COMPLETE AND, IF PATIENT MEETS CRITERIA, RETURN PAGES 2 AND 3**

Weston Hospicecare provides specialist palliative care for people with life-limiting illnesses, both malignant and non-malignant disease, and support for their families/carers, given by a professional multi-disciplinary team.

WHEN COMPLETING FORM PLEASE TICK THE BOXES THAT APPLY AGAINST EACH STATEMENT

**IT WILL DELAY REFERRAL IF THIS IS NOT COMPLETED**

**1.Referral Principles -** All referral principles must be satisfied:

The patient must be aged 18 years or over and be suffering from a progressive life-limiting illness.

The patient must live within, and/or be registered with a GP located within, the area covered by our services. Occasional exceptions can be made for In Patient Unit referrals, after negotiation.

**The patient must agree to the referral (or family member if sufficient mental capacity does not exist).**

Referrals should be based on the individual’s overall needs, rather than diagnosis alone.

**Patient should be aware of their diagnosis.**

**2.Referral Criteria -** In addition to satisfying the referral principles, patients must meet one or more of referral criteria:

Experiencing complex and severe symptoms, which have not adequately responded to routine treatments and interventions from the other services and care providers involved in their care.

Due to the level of complexity and intensity their needs cannot solely be met by other services/care providers.

Dying is complicated by complex symptoms and psychological/spiritual/social distress in-patient or family.

Patients and their carers are having psychological/spiritual/emotional difficulties adjusting and coping with their disease and generalist support has not been able to meet their needs.

There are complex ethical issues around treatment and related decision-making (Please include details of this if applicable).

**AND** one or more of referral criteria:

Uncontrolled and severe symptoms are not responding to first line management.

Rapid changes in condition where urgent assessment is required to inform clinical management decisions and appropriate place of care.

High levels of anxiety/distress are affecting on going care and treatment.

No other specialist palliative care service is involved.

**Prior to a first visit the patient will be made aware that following a clinical assessment they may not be taken onto Weston Hospicecare caseload, if it is felt inappropriate to do so i.e. they do not meet our criteria.**

Patients and families can self-refer though we will contact their GP to verify that referral criteria are satisfied.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | | | | | | | | |
| **SURNAME** | | | | | **TITLE**  MR MRS MISS MS | | | | | **EMIS NO:** | | |
| **FIRSTNAME** | | **OTHER INITIALS** | | | **SEX:**  M F | | | **ETHNIC ORIGIN**:  W B I A OTHER | | | **MARITAL STATUS:**  M S W D OTHER | |
| **D.O.B.** | | | | **NHS NO** | | | | | **OCCUPATION:** | | | |
| **ADDRESS:** …………………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………**POST CODE:** ……………………………………….. | | | | | | | | | | | | |
| **TEL NO:** | **HOME:** | | | | **MOBILE:** | | | | | | | |
|  |  | | | | **EMAIL:** | | | | | | | |
| **NEXT OF KIN** | | | | | | | | | | | | |
| **SURNAME** | | | **FIRST NAME** | | | | | | | | | **RELATIONSHIP**  Husband  Wife  Son  Daughter  Partner  Parents  Other |
| **ADDRESS:** ……………………………………………………………………………………………………………………..………  ………………………………………………………………………………………………………………………………………..……...  ………………………………………………………………………………………………………**POST CODE:** ………………….. | | | | | | | | | | | |
| **TEL NO:** | **HOME:** | | | | **MOBILE:** | | | | | | | |
| **DATE OF BIRTH** |  | | | | **EMAIL:** | | | | | | | |
| **PATIENT DETAILS CONT.** | | | | | | | | | | | | |
| **GP:** | | | | | | | **HOSPITAL CONSULTANT:** | | | | | |
| **PRACTICE:** | | | | | | | **HOSPITAL:** | | | | | |
| **TEL NO:** | | | | | | | **PATIENT HOSPITAL NO.:** | | | | | |
| **SPECIALIST NURSE:** | | | | | | | **HOSPITAL TEL NO:** | | | | | |
| **PRIMARY DIAGNOSIS:** | | | | | | | | | | | | |
| **OTHER SIGNIFICANT DIAGNOSES:** | | | | | | | | | | | | |
| **REASON FOR REFERRAL/SYMPTOMS:**  1. Terminal care  2. Pain control  3. Symptom control (please specify)  4. Psychological/Emotional/Social support | | | | | | **SERVICE TO WHICH YOU ARE REFERRING:**  1. Inpatient unit  2. Hospice Community Nurse Specialist  3. Spiritual Care  4. Family Support Team – Emotional Support  5. Day Hospice Programme  6. Gardening, Arts & Peer Support Group  7. Advanced Care Planning (Arts Based)  8. Expressive Movement Psychotherapy  9. Physiotherapy | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **FURTHER DETAILS AND ANY OTHER RELEVANT INFORMATION**  **(Including any further medical history, current or past treatment, social or psychological needs, any known risks and/or any medication idiosyncrasies)**  **Current mobility (including any aids):**  **Oxygen requirements:**  **Other services involved:** | | | | | |
| PATIENT CURRENT STATUS USING PALLIATIVE CARE ASSESSMENT TOOLS PHASE OF ILLNESS AND AUSTRALIAN KARNOSFSKY PERFORMANCE STATUS (AKPS) | | | | | |
| PHASE OF ILLNESS  (Please tick) |  | **Stable**  Patient’s problems and symptoms are adequately controlled by established plan of care. Further intervention to maintain symptom control and quality of life have been planned and family/carer situation is relatively stable and no new issues apparent. | | | |
|  | **Unstable**  An urgent change in the plan of care or emergency treatment is required because the patient experiences a new problem that was not anticipated in the existing plan of care and/or the patient experiences rapid increase in the severity of current problem and/or family/care giver’s circumstances change suddenly impacting on patient care | | | |
|  | **Deteriorating**  The care plan is addressing anticipated needs but requires periodic review because the patient’s overall functional status is declining and the patient experiences a new but anticipated problem and/or the family/carer experience gradual worsening distress that impacts on the patient care | | | |
|  | **Dying**  Dying phase/death is likely within days | | | |
| AKPS  (Please tick) |  | 100% Normal, no complaints, no evidence of disease | | | |
|  | 90% Able to carry on normal activity, minor signs or symptoms of disease | | | |
|  | 80% Normal activity with effort, some signs or symptoms of disease | | | |
|  | 70% Cares for self but unable to carry on normal activity or do active work | | | |
|  | 60% Able to care for most needs but requires occasional assistance | | | |
|  | 50% Considerable assistance and frequent medical care required | | | |
|  | 40% In bed for more than 50% of the time | | | |
|  | 30% Almost completely bedfast | | | |
|  | 20% Totally bedfast and requiring extensive nursing care by professionals and/or family | | | |
|  | 10% Comatose or barely rousable, unable to care for self, requires equivalent of institutional or hospice care, disease may be progressing rapidly. | | | |
| **Has the GP been informed of this referral?** | | | | **YES** | **NO** |
| **REFERRAL PROCESS**  Patients referred to a Hospice Community Nurse Specialist will be contacted by telephone **within 2 working days of the referral being accepted.** If you are seeking a faster/more urgent response, please contact one of the Hospice Community Team on 01934 423900.  Patients referred to any other service will be contacted **within 2 weeks.**  For referrals to the Inpatient Unit please liaise directly with the Unit via the main hospice switchboard (01934 423900) prior to completing the referral form.  **Please return the completed referral form along with a GP summary, current medication list and relevant hospital letters/scans via email to** [**medsecs.hospice@nhs.net**](mailto:medsecs.hospice@nhs.net) **, or post to the address at the top of the form, for the attention of the medical secretaries.** | | | | | |
| **REFERRED BY:** | | | **DESIGNATION:** | | |
| **CONTACT NUMBER:** | | | **DATE OF REFERRAL:** | | |