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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**HusbandWifeSonDaughterPartnerParentsOther |
| **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 unit2. Hospice Community Nurse Specialist3. Spiritual Care4. Family Support Team – Emotional Support5. Day Hospice Programme6. Gardening, Arts & Peer Support Group7. Advanced Care Planning (Arts Based)8. Expressive Movement Psychotherapy9. 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** **, 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:**  |