WESTON HOSPICECARE

Jackson-Barstow House,
28 Thornbury Road,
Uphill, Weston-super-Mare,
BS23 4YQ.
Tel. 01934 423900
Email: Medsecs.hospice@nhs.net

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.

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.
- The patient must agree to the referral (or family member if sufficient mental capacity does not exist).
- Patients and families can self-refer though we will contact their GP to verify that referral criteria are satisfied.
- Referrals should be based on the individual's overall needs, rather than diagnosis alone.
- Patient should be aware of their diagnosis.

Referral Criteria - In addition to satisfying the referral principles, patients must meet one or more of referral criteria 1-5:

1. 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.
2. Due to the level of complexity and intensity their needs cannot solely be met by other services/care providers.
3. Dying is complicated by complex symptoms and psychological/spiritual/social distress in-patient or family.
4. 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.
5. 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 6-9:

6. Uncontrolled and severe symptoms are not responding to first line management.
7. Rapid changes in condition where urgent assessment is required to inform clinical management decisions and appropriate place of care.
8. High levels of anxiety/distress are affecting on going care and treatment.
9. 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.

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:**
		EMAIL:

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. Family Support Team 4. Day Services 5. Physiotherapy

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:

The information entered onto this form is in CONFIDENCE and bound by the General Data Protection Regulations 2018

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.

Is the patient aware of diagnosis?	**YES**	**NO**
Is the patient aware of this referral?	**YES**	**NO**
Has the GP been informed of this referral?	**YES**	**NO**

REFERRAL PROCESS

Patients referred to a Hospice Community Nurse Specialist team will be contacted by telephone **within 2 working days of receipt of referral.** If you are seeking a faster/more urgent response, please contact one of the hospice Community Team on 01934 423900.
Patients referred to the Family Support Team, Day Services and/or Physiotherapy 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:**