

NORTH DURHAM PALLIATIVE CARE SERVICE

REFERRAL FOR SERVICE: Yes No

INFORMATION TRANSFER ONLY:

| Service Required: | | Referral agreed with: | |
|-------------------|---|-----------------------|---|
| | <input type="checkbox"/> Domiciliary Visit <input type="checkbox"/> Ward Consultation <input type="checkbox"/> Hospice Care (<i>specify overleaf</i>): <input type="checkbox"/> Willowburn Hospice <input type="checkbox"/> St Cuthbert's Hospice | 3 | <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> District Nurse <input type="checkbox"/> GP <input type="checkbox"/> Hospital Consultant |
| | | 16 | |

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|----|---|---|----|--------------------------------|---------|
| 1 | Referral Date: | | | 2 Referred by: | |
| 4 | Name: | DOB: | | Designation: | |
| 5 | Address: | | | Contact Tel No: | |
| | Postcode: | | 15 | GP: | |
| | | | | Tel No: | |
| 6 | Tel No: | NHS No: | 11 | District Nurse: | Tel No: |
| | Lives alone: <input type="checkbox"/> | Ethic Group: | | Specialist Nurse: | Tel No: |
| 9 | Carer/NOK: Address: | | | Social Services: | Tel No: |
| | Telephone No: Relationship: | | 10 | Hospital Consultants: | Tel No: |
| | Key Worker: | Leaflet given: <input type="checkbox"/> | | | |
| 12 | Diagnosis: | | 13 | Is patient aware of diagnosis? | |
| 8 | Reason for Referral: <input type="checkbox"/> Pain/Symptom Management <input type="checkbox"/> Carer Support <input type="checkbox"/> Social Financial Support <input type="checkbox"/> Emotional Support | | 14 | Is carer aware of diagnosis? | |
| | | | | Current Medication: | |
| | | | | Allergies: | |
| | Additional Information/Treatment to Date: | | | | |
| 18 | Date of Initial Contact: | | 19 | Date of 1 st Visit: | |
| 20 | Response Time: | | 17 | Level of Intervention: | |

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| Disch | | Disch | | Disch | | Disch | |
| Re-entry | | Re-entry | | Re-entry | | Re-entry | |

| Please fax completed form to the appropriate team: | | | |
|---|-------------------|---|---|
| University Hospital of North Durham Palliative Care Team | Fax: 0191 3332338 | Community Palliative Care Consultant (Dr Crack) | Fax: 0191 3843941 |
| Durham & Chester-le-Street Palliative Care Team | Fax: 0191 3876534 | Willowburn Hospice | Fax: 01207 529303 |
| Derwentside Palliative Care Team | Fax: 01207 594599 | St Cuthbert's Hospice - Day Care For In-Patient Unit (IPU) only | Fax: 0191 3831698 Fax: 0191 384 3941 |

HOSPICE SERVICE

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| Hospice: <input type="checkbox"/> St Cuthbert's Hospice <input type="checkbox"/> Willowburn Hospice | Service: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Day Care <input type="checkbox"/> Day Treatment | How soon is the service needed: <input type="checkbox"/> Urgent (within 24 hours) <input type="checkbox"/> ASAP <input type="checkbox"/> Planned date |
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INPATIENT

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| Reason for admission: <input type="checkbox"/> Symptom control <input type="checkbox"/> End of life care <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Respite (planned admission) | Is the patient MRSA positive? <input type="checkbox"/> Yes <input type="checkbox"/> No DNAR status decided? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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PALLIATIVE NEEDS & SPECIAL REQUIREMENTS:
(e.g. Oxygen, feeding pump, special mattress/hoist)

OUTPATIENT

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| <input type="checkbox"/> Medical outpatient <input type="checkbox"/> Breathlessness clinic <input type="checkbox"/> Lymphoedema clinic | Therapy clinic (<i>please specify</i>): <input type="checkbox"/> Occupational therapist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Complementary therapies <input type="checkbox"/> Counselling/psychological support |
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| DAY CARE | TRANSPORT REQUIREMENTS |
|----------|------------------------|
|----------|------------------------|

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| <input type="checkbox"/> Day care <input type="checkbox"/> Day treatment (<i>please specify</i>): <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Bisphosphonate infusion | <input type="checkbox"/> Own transport <input type="checkbox"/> Volunteer driver <input type="checkbox"/> Ambulance |
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| HOSPICE ADMIN: | | | |
|-------------------------------------|-------|-------------------------------------|-------|
| <input type="checkbox"/> Notes sent | Date: | <input type="checkbox"/> Notes sent | Date: |