

**Living Well Centre at St Cuthbert’s Hospice**

Outpatient Services for those with Specialist Palliative Care Needs

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| Title: | Surname: | Forenames: | Known as: |
| D.O.B: | Age: | Sex: M / F  | NHS No: | Date of Referral: |

Please ensure that this form is fully completed or it may be rejected and returned to the referrer for completion

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| --- | --- |
| Address:Postcode: | Referral:Standard Urgent |
| Referred By:Designation:Contact: |
| Telephone No: | Lives Alone:Yes / No  |
| Ethnic Group:Interpreter Required: Yes / No  | Religion: | GP:Address:Tel No: |
| Diagnosis/Date: |
| Is patient aware of diagnosisYes / No  | Is carer aware of diagnosisYes / No  | MacMillan Nurse: | Tel No: |
| Carer/NOK and relationship:Address:Tel No: | District Nurse: | Tel No: |
| Clinical Nurse Specialist: | Tel No: |
| Informed consent obtained to referral with:Patient NOK/carer Health or Social care professionals consulted/notified regarding the referral:GP District Nurse Macmillan Nurse Consultant Specialist Nurse Other …………………………………………………………………………………… | Consultant:Previous or present occupation: | Tel No: |



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| **Reason for referral:** | **Additional support required:** |
|  **Pain/symptom management** |  **Carer support** |  **Breathlessness management** |
|  **Psychological/emotional support** |  **Family Support Team - counselling** |  **Fatigue management**  |
|  **Palliative Rehabilitation** |  **Occupational Therapy** |  **Complementary therapies**  |
|  **Spiritual support**  |  **Physiotherapy** |  **Admiral Nurse**  |
|  **Social support**  |  **Social Worker**  |  **Creative Therapies**  |
|  **Cognitive Stimulation Therapy** |  **Nursing Support**  |  **Relaxation Therapies**  |

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| **Lone worker risks**Is there a risk of physical/verbal aggression? Yes 🞎 No 🞎Is there a history of alcohol or drug dependency? Yes 🞎 No 🞎Relevant mental health issues? Yes 🞎 No 🞎Any pets at home? Yes 🞎 No 🞎 If yes to any of the above, or any other known risks please comment below: | **Advanced decisions/statements**EHCP:Discussed: Yes 🞎 No 🞎 Completed: Yes 🞎 No 🞎LPA:Discussed: Yes 🞎 No 🞎 Completed: Yes 🞎 No 🞎DNACPR:Discussed: Yes 🞎 No 🞎 Completed: Yes 🞎 No 🞎Any other advanced decisions/statements completed or discussed:  |
| **Preferred place of care:**  | **Preferred place of death:**  |



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| Relevant medical history including medication, allergies and any current nursing interventions: | Social History: |
| Any other relevant information including the situation leading up to this referral:Any PMH of cognitive impairment (please state if any recent assessments complete) |
| Additional information: Oxygen therapy 🞎 Syringe Driver 🞎 Wounds/pressure damage 🞎 Known infection 🞎If yes to any of the above, or any other relevant information please comment below: |

Referral completed by:

Designation:

Date:

Please return this referral form by email to:

NECNE.StCuthbertsHospiceReferrals@nhs.net

**Living Well Centre**

St Cuthbert’s Hospice

Park House Road

Durham

DH1 3QF

Tel: 0191 386 1170