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**HALTON and WARRINGTON SPECIALIST PALLIATIVE CARE REFERRAL FORM**

Completed form to be sent to:

**Warrington Integrated Palliative Care Hub** **[warccg.srhspa@nhs.net](mailto:warccg.srhspa@nhs.net)Tel: 03333 661066**

**Halton Community Specialist Palliative Care Team** [bchft.haltonspct@nhs.net](mailto:bchft.haltonspct@nhs.net) **Tel: 01928 714 927**

**Halton Haven Hospice** [haltonhavenhospice.inpatients@nhs.net](mailto:haltonhavenhospice.inpatients@nhs.net) **Tel: 01928 712728**

**REFERRER DETAILS**

|  |  |
| --- | --- |
| Name | Designation |
| Service | Ward |
| Address | Postcode |
|  |  |
| Tel No | NHS email/secure email |

**PATIENT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname: | Forename: | | | Known as: |
| Date of Birth: | NHS Number: | | | |
| Home/Care Home Address: | | | | |
| Postcode: | Tel No: | | | Email: (if applicable) |
| Current place of Care (if different from above) | | | | |
| Marital Status: | Dependents | | | |
| Ethnic Group: | Religious Beliefs/considerations for after death care: | | | |
| Any barriers to communication? Yes / No Is an interpreter required? Yes / No  (Give details) | | | | |
| **NEXT OF KIN DETAILS/MAIN CARER DETAILS** | | | | |
| Surname: | First name: | | | Relationship: |
| Address/Postcode: | Tel No: | | | Email: |
| Is patient aware of referral Yes / No | Is carer aware of referral Yes / No | | | |
| **GENERAL PRACTITIONER** | | | | |
| GP/Practice Name: | | | Is GP aware of referral? Yes / No | |
| Address/Postcode: | | Tel No: | | Email: |

**CLINICAL DETAILS**

|  |
| --- |
| Diagnosis & extent of disease: (including date(s) of diagnosis) |
| Estimated prognosis/GSF Status*(Please tick as appropriate)*:  Hours (Red)  Days (Red)  Weeks (Amber)  Months(Green) More than a year (Blue) |
| Important events and treatments: i.e., Long Term Oxygen Therapy |
| Other related conditions: |
| Any specific nursing/therapy needs: |
| Medication/Allergies: |
| Medical Devices:  Has the patient been fitted with: A cardiac pacemaker/implanted defibrillator? Yes / No  A radioactive or other implant? Yes / No  Syringe driver in situ? Yes / No (If yes) Owner ………………………… Asset No ……………………… |
| **Documentation in place** (please circle) |
| Yes / No / N/A Gold Standard Framework (GSF)/Supportive Care Register  Yes / No / N/A EPACCS/Future Care Plan (Consent to share)  Yes / No / N/A Ceiling of Clinical Treatment/Treatment Escalation Plan  Yes / No / N/A Do Not Attempt Resuscitation (DNA CPR)  Yes / No / N/A Advance Care Plan (ACP)  Yes / No / N/A Living Will/Advance Directive  Yes / No / N/A Preferred Place of Care (PPC)  Yes / No / N/A Lasting Power of Attorney (POA): Health & Welfare \_\_\_ Property & Financial\_\_\_  Yes / No / N/A End of Life Drugs  Yes / No / N/A Individual Plan of Care for the Dying Person (IPOC)  Yes / No / N/A CHC Fast Track referral  Yes / No /N/A Rockwood Assessment |

**REASON FOR REFERRAL**

|  |  |
| --- | --- |
| **Problem**  Physical Symptom management i.e., Pain, Nausea and Vomiting, etc.  Emotional/psychological support required (complex/reassurance)  Current management plan in place  Current medication in relation to current symptoms  Relevant medication prescribed and failed  Advance care planning  Carer support  End of life care  Other reason  **Consider for Palliative Virtual Ward** | **Details** |

|  |  |
| --- | --- |
| **Patient Knowledge** *(Please circle):* | **Family Knowledge** *(Please circle):* |
| Patient consented to referral Yes / No  Mental Capacity Assessment / Best Interests Decision Yes / No  Date completed………………….. By whom………………………….  Patient aware of diagnosis Yes/ No  Patient aware of prognosis Yes / No  Expectations of referrer Patient/carer | Family aware of referral Yes/ No  Family aware of diagnosis Yes / No  Family aware of prognosis Yes / No |

**CURRENT SERVICES INVOLVED**

|  |  |
| --- | --- |
| Consultant | Name: Base: Tel No: |
| Consultant | Name: Base: Tel No: |
| Oncology Consultant | Name: Base: Tel No: |
| Specialist Palliative Care Team | Name: Base: Tel No: |
| Specialist Nurses | Name: Base: Tel No: |
| Hospice | Name: Base: Tel No: |
| District nurse | Name: Base: Tel No: |
| Therapists (Physio, OT) | Name: Base: Tel No: |
| Psychologist/Counsellor | Name: Base: Tel No: |
| Social Services | Name: Base: Tel No: |
| Continuing Health Care | Name: Base: Tel No: |
| Other (Agency) | Name: Base: Tel No: |

**SOCIAL SITUATION**

|  |  |
| --- | --- |
| Housing description | Access |
| Lives alone Yes / No | Housebound Yes / No |
| Equipment (in situ) | Equipment (required) |
| Benefits (received) | Benefits (to be sourced) |
| Existing Package of Care (PoC) give details: | PoC Funding |

**Urgency of Need** (Please indicate with a cross responses to the prompts below)

If a medical emergency is suspected or impending (e.g. spinal cord compression, SVC obstruction, airway obstruction, seizures, acute bleeding) or psychiatric emergency (e.g. agitated delirium, suicidality) then contact GP for Urgent Medical assessment, as referral may not be appropriate.

|  |
| --- |
| 1. Physical suffering or distress of patient  Unknown 0  Nil 0  Mild 0  Moderate 14  Severe 32  2. Psychological or spiritual suffering or distress of patient  Unknown 0  Nil 0  Mild 0  Moderate 6  Severe 14  3. Distress or burnout of caregiver  Unknown 0  Nil 0  Mild 0  Moderate 5  Severe 13  4. Urgent or complex communication or information needs of patient or caregiver  Unknown 0  No 0  Yes 8  5. Significant discrepancy between care needs and care arrangements  Unknown 0  Nil 0  Impending 6  Current 10  6. Mismatch between current place of care and preferred place pf care  Unknown 0  No 0  Yes 9  7. Patient is imminently dying (felt to be in last days or hours of life)  Unknown 0  No 0  Yes 14 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** | **Signature:** | **Designation:** | **Date:** |

*For Office Use Only*

|  |  |  |
| --- | --- | --- |
| *RUN-PC Triage Tool Calculator Score (Ref: RUN-PC Triage Tool © St Vincent’s Hospital (Melbourne) Ltd 2019)* | | |
| ***Category*** | ***Definition*** | ***Scores*** |
| ***Inpatient Unit setting*** |  |  |
| *1. Crisis* | *Requiring admission to inpatient palliative care unit within 24 hrs* | *51 -100* |
| *2. Urgent* | *Requiring admission to inpatient palliative care unit within 48 hrs* | *41 - 50* |
| *3. Non-urgent* | *Requiring admission to inpatient palliative care unit within 72 hrs* | *21 - 40* |
| *4. Routine* | *Requiring admission to inpatient palliative care unit within 7 days* | *0 -20* |
| ***Hospital Consultation*** |  |  |
| *1. Crisis* | *Requiring palliative care hospital consultation within 24 hrs* | *31 - 100* |
| *2. Urgent* | *Requiring palliative care hospital consultation within 48 hrs* | *11 - 30* |
| *3. Non-urgent* | *Requiring palliative care hospital consultation within 72 hrs* | *0 - 10* |
| ***Community setting*** |  |  |
| *1. Crisis* | *Requiring community palliative care consultation within 24 hrs* | *31 - 100* |
| *2. Urgent* | *Requiring community palliative care consultation within 72 hrs* | *21 - 30* |
| *3. Non-urgent* | *Requiring community palliative care consultation within 7 days* | *11 - 20* |
| *4. Routine* | *Requiring community palliative care consultation within 14 days* | *0 -10* |
| ***Palliative Virtual Ward (Warrington Only)*** |  |  |
| *1. Crisis* | *Requiring same day onboarding for Palliative Virtual Ward* | *51 -100* |
| *2. Urgent* | *Requiring same day onboarding for Palliative Virtual Ward* | *41 - 50* |