GT Yarmouth & Waveney Specialist Palliative Care Team Referral Form

Referrals are accepted for patients over 18 years of age with a life limiting/progressive illness at any time following diagnoses and/or who have unresolved/complex symptoms/complex psychosocial/spiritual needs that cannot be met by the usual health care profession team. This may include complex family needs as well.

The patient needs to consent to the referral unless they do not have capacity to do so.

You can also contact the **SPC team for advice, 7 days a week 24 hours a day on 08005670111**.

Please **post completed form to Beccles hospital, St Mary's Road, Beccles NR34 9NQ**. The Specialist Palliative Care Nurses will triage all new referrals that are received. All triaged patients assessed to have a SPC need, will have a specialist palliative care holistic needs assessment in order to identify specialist needs. This will ensure that patients receive the appropriate care by the right professional. NB. The highlighted sections are essential to acceptance of the referral.

Hospital Number: NHS NO: Name: D.O.B: Address:	Is the patient at home: Yes ☐ No ☐ Patient Contact No: .... Other location, please state (inc Hospital/Ward):.................................. Contact number at patient's location:... Patient aware of and agree to referral: Yes ☐ No ☐ Is this a referral in patient's Best Interests due to lack of capacity? Yes ☐ Family aware of and agree to referral: Yes ☐ No ☐ Has patient consented to sharing of information(EDSM):Yes ☐ No ☐ Is patient aware of diagnosis: Yes ☐ No ☐
GP: Surgery: GP contact number:	***Carer/Next of kin details*** Name of main carer/next of kin: Relationship to patient: Contact details: (if applicable)
If the patient requires an interpreter, please specify language	
Accessible Information Standards	
Does the service user have additional needs related to:	Please specify below as applicable:
Vision	
Hearing	
Speech	
Other communication difficulties	
Is this referral for: Hospice SPC inpatient admission (Beccles) ☐ JPUH hospital assessment ☐ Community assessment ☐	
What are you hoping we can help with?	

Brief history of diagnosis and key treatments:	Date of diagnosis:

Primary Reason/s for referral	Current problems (please tick)
Pain Management ☐ Symptom Management ☐ Emotional/psychological support ☐ Social/financial ☐ Spiritual ☐ Carers needs ☐ Other (Please specify)……………………..	Pain ☐ Constipation ☐ Mobility ☐ Vomiting/Nausea ☐ Diarrhoea ☐ Communication ☐ Anorexia ☐ Anxiety ☐ Social ☐ Breathlessness ☐ Depression ☐ Confusion ☐ Psychological ☐ Other (Please specify)………………………….. Mobility issues: Equipment needs Lone-worker concerns Any hazards in the home/ risks to be aware of:

Advance care planning
Does the patient have an advance care plan document: If yes, then which ones? Preferred Place of Care ☐ death ☐ CPR status☐ Advance Decision to refuse treatment☐ Other☐ No☐ Don't know☐ If yes where is the preferred place of care/death:
Is the patient on the Gold Standards Framework Register: Yes☐ No☐ If yes please specify……………………………

Other professionals involved (name and telephone number)	
Consultant(s):	District/Community Nurse:
Clinical Nurse Specialist:	Social Services:

Referrer's details	
Name of Referrer: (print)	Signature of Referrer:
Designation:	Department:
Contact No:	**Date of Referral:**