Hospice Isle of Man care for our community

REFERRAL FORM FOR SERVICES PROVIDED BY
HOSPICE ISLE OF MAN

NB: Referrals for Lymphoedema management must be on the dedicated Referral Form

Referral Criteria
For access to services the patient should fulfil the three criteria below:

1. The patient has specialist palliative care needs.
2. The patient has active and progressive disease
3. The needs of the patient can be met by services provided by Hospice IOM and that Hospice IOM is the most appropriate agency to provide these services.

Surname:	NHS No:
First name(s): Address: Post Code: **Contact Telephone Number** :	**Next of kin / Patient representative:** Name: Address:
Male ☐ Female ☐ Ethnicity: Interpreter required: Yes ☐ No ☐ Occupation: Special considerations e.g. Disability, belief system affecting care. Please state ……………………………………………	Telephone Home: Mobile: Relationship to patient:
Marital status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Cohabiting ☐ Widowed ☐ Unknown ☐	
Patient Lives Alone: Yes ☐ No ☐ **Patient is currently:** ☐ In hospital Ward…….. ☐ At home ☐ Elsewhere Please state……………………………….	**General Practitioner** Name: Practice: Telephone: Fax:
Diagnosis(es): **Please state Date of Diagnosis: ……………………..**	**If Cancer; site of metastases (and date discovered)**
Hospital Consultants:	**Is there a Specialist Nurse involved?** Yes ☐ No ☐ Cancer CNS (if yes which?): Heart failure ☐ Respiratory ☐ MND ☐ Parkinson's ☐ Mental Health ☐ Renal ☐ Long Term Conditions Co-ordinator ☐ Haematology ☐ Other ☐

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Patient Name:

Hospice Service Required:

☐ Palliative Care CNS
☐ Fatigue & Breathlessness Programme
☐Complementary Therapy
☐ Medical Outpatient Clinic
☐ Scholl Wellbeing Centre Day Therapy
☐ Social Worker
☐Complex Psychological Support
☐Admission into Hospice In-Patient Unit **for:** Terminal Care☐Symptom Management☐ Respite Care☐

Attendance:

Is the patient able to attend the Hospice for their appointment?

Yes ☐ No ☐

Urgency of referral

☐ Urgent: Hospice will contact within 1 – 2 working days **(if urgent please state why):**
☐ Routine: Hospice will contact within 3 – 5 working days
All referrals received will be triaged at 9.30am each working day

What are the key concerns that require Specialist Palliative Care input?

Please state as fully as possible the main problems that have led to the request for specialist palliative care assessment**:**

Please tick the boxes if the patient is experiencing any of the symptoms below:

☐ Pain	☐ Fatigue	☐ More dependent for care
☐ Nausea	☐ Depression	☐ Agitation
☐ Anorexia	☐ Anxiety (patient)	☐ Sleep Disturbance
☐ Vomiting	☐ Anxiety (family)	☐ Confusion
☐ Dyspnoea	☐ Spiritual distress	☐ Weakness
☐ Oral Problems	☐ Socially Isolated	☐ Drowsiness
☐ Bowel Problems	☐ Reduced Mobility	☐ Opioid Toxicity
☐ Bladder Problems		

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Patient Name:

Australia-modified Karnofsky Performance Status: Please indicate the patient's performance status by checking a box:

100%	Normal, no complaints, no evidence of disease.	☐
90%	Able to carry on normal activity with effort, some 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 to 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 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 hospital care, disease may be progressing rapidly.	☐
0%	Dead	☐

Has any advance care planning discussion taken place? If so what are the outcomes?

Is DNACPR completed? Yes ☐ No ☐

Estimated Prognosis: ☐ Days ☐ Weeks ☐ Months

DS 1500 Completed Yes ☐ No ☐

Past Medical History:

Current Medication:

Details of current treatment plan:

Allergies:

Awareness of Diagnosis/Prognosis /Referral to the Hospice

	Patient	Family/Carer
Diagnosis:	Yes ☐ No ☐	Yes ☐ No ☐
Prognosis:	Yes ☐ No ☐	Yes ☐ No ☐
Referral:	Yes ☐ No ☐	Yes ☐ No ☐

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Source of Referral:	**Patient Name:**
Name: Address Post code Telephone Number: Signature:	☐ General Practitioner ☐ Hospital Consultant /Medical team ☐ Clinical Nurse Specialist includes OPAS Nurse ☐ Senior Allied Health Professional ☐ District Nursing Team Leader/ Long Term Conditions Co-ordinator ☐ UK Hospital **Hospital use only** - Consultant aware of this referral? Yes ☐ No ☐ **Community use only** – GP aware of this referral? Yes ☐ No ☐ Date:

Please ensure patients are aware this information will be held on computer according to the General Data Protection Regulations and that our privacy notice is available on the Hospice Isle of Man website.

Does the patient agree to Hospice clinical staff accessing their GP and Hospital clinical record?

Yes ☐ No ☐ If No, is there any particular reason for this? Please state:

……

In order to make an accurate assessment this form <u>will be returned</u> if not fully completed.

If we have to contact you for further details, there will be a delay in processing the referral.

Please send copies of recent clinical correspondence with this form.

*** Please fax this referral form to FAX NO. 01624 647460 or post to the Clinical Administrator, Hospice Isle of Man, Strang, Douglas IM4 4RP**

***All patients will be subject to caseload review and will be discharged once their identified specialist palliative care needs have been met. ***

For Official Use Only: **Date referral received: ……………………**

PCCNS Triage: ……………………….

Key Worker: …………………………. **Date passed to key worker: ……………………..**

Action/Outcome:

Signature: ………………….. **Date: ……………………….**