HALTON and WARRINGTON SPECIALIST PALLIATIVE CARE REFERRAL FORM

Completed form to be sent to:

Warrington Integrated Palliative Care Hub cmicb-war.srhspa@nhs.net **Tel: 03333 661066**

Halton Haven Hospice haltonhavenhospice.inpatients@nhs.net **Tel: 01928 712728**

Halton Community Specialist Palliative Care Team bchft.haltonspct@nhs.net **Tel: 01928 714 927**

REFERRER DETAILS

Name <Sender Name>	Designation
Service <Sender Details>	Ward
Address <Organisation Address>	Postcode <Organisation Address>
Tel No <Organisation Details>	NHS email/secure email <Organisation Details>

PATIENT DETAILS

Surname: <Patient Name>	Forename: <Patient Name>	Known as: <Patient Name>
Date of Birth: <Date of Birth>	NHS Number: <NHS number>	
Home/Care Home Address: <Patient Address>		
Postcode: <Patient Address>	Tel No: <Patient Contact Details>	Email: (if applicable) <Patient Contact Details>
Current place of Care (if different from above):		
Marital Status: <Marital Status>	Dependents:	
Ethnic Group: <Ethnicity>	Religious Beliefs/considerations for after death care: <Religion>	
Any barriers to communication? ☐ Yes ☐ No Is an interpreter required? <Main spoken language> ☐ 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: <Organisation Details>	Is GP aware of referral? ☐ Yes ☐ No	
Address/Postcode: <Organisation Address>	Tel No: <Organisation Details>	Email: <Organisation Details>

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

REASON FOR REFERRAL

Problem	**Details (Please provide as much detail as you can)**
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 (Applies to Warrington Place Only)**	

Urgency of Need (Please indicate with a tick response 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 ☐ Yes 14 ☐

CLINICAL DETAILS

Estimated prognosis/GSF Status *(Please tick as appropriate)*:

<Palliative Care View (view)>

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:

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 tick)

☐ 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

Patient Knowledge *(Please tick):*	**Family Knowledge** *(Please tick):*
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:

Medication/Allergies:

<Medication>

<Allergies & Sensitivities>

Diagnosis & extent of disease: (including date(s) of diagnosis in last 12 months)
<Problems>

Referrer Name: **<GP 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*