

**CONFIDENTIAL**

**PLEASE ANSWER ALL QUESTIONS FULLY  
INCOMPLETE FORMS WILL CAUSE  
DELAY IN THIS REFERRAL BEING PROCESSED**



**HOSPICE NUMBER:** .....

**APPLICATION FOR HOSPICE SERVICES**

*Please return completed form to:*

**Referrals Secretary, Saint Francis Hospice**

The Hall, Havering-atte-Bower, Romford, Essex, RM4 1QH

Telephone: 01708 753319

Registered Charity No. 275913

Fax: 01708 757957

**Please Note:** Telephone enquiries are welcome; referrals for services are accepted by post or fax.

**[Revised: May 2010]**

<b>PATIENT:</b> Mr/Mrs/Miss/Ms/Other .....	NHS Number: .....
Surname: .....	PCT: .....
Forenames: .....	STATUS: Single Co-habiting Married Separated Divorced Widowed
Address: .....	Date of Birth: ..... Age: .....
.....	Occupation: .....
.....	Spiritual/Religious Belief: .....
..... Post Code: .....	First language: .....
Tel No – home: .....	Translation needs: Patient: .....
mobile: .....	Family: .....

<b>MAIN CARER:</b> .....	<b>NEXT OF KIN (if different):</b> .....
Relationship to Patient: .....	Relationship to Patient: .....
Address: .....	Address: .....
..... Post Code: .....	..... Post Code: .....
Tel No. (home) ..... (work) .....	Tel No. (home) ..... (work) .....

**GENERAL PRACTITIONER:** .....

Address: .....

Post Code: ..... Tel No: ..... Fax No: .....

**DISTRICT NURSE:** ..... Tel No: ..... Fax No: .....

**SOCIAL WORKER:** ..... Tel No: ..... Fax No: .....

**OTHER AGENCY:** ..... Tel No: ..... Fax No: .....

<b><u>HOSPITAL CONSULTANTS</u></b>	<b><u>SPECIALITY</u></b>	<b><u>HOSPITAL</u></b>	<b><u>TEL NO.</u></b>
.....	.....	.....	.....
.....	.....	.....	.....

**DIAGNOSIS: Principal** .....

**Date of diagnosis** .....

**Other** .....

**Date of diagnosis** .....

**EXTENT OR STAGE OF DISEASE:**

**TREATMENT:** Including investigation/surgery/radiotherapy/chemotherapy/ICD/artificial nutrition/ventilation/other

**OTHER RELEVANT MEDICAL ISSUES:**

**ALLERGIES:**

**CURRENT MEDICATION:** Including dosage (please continue on separate sheet if necessary)

.....  
.....  
.....  
.....  
.....  
.....  
.....

**What are the main reasons for referral? (Please tick – you may need more than one):**

- |  |                          |  |                          |                       |                          |
|--|--------------------------|--|--------------------------|-----------------------|--------------------------|
| Terminal care  | <input type="checkbox"/> | Therapeutic procedure<br><small>(PLEASE STATE BELOW)</small> | <input type="checkbox"/> | Social Support        | <input type="checkbox"/> |
| Pain control   | <input type="checkbox"/> | Lymphoedema management                                       | <input type="checkbox"/> | Patient/Carer support | <input type="checkbox"/> |
| Other symptom control<br><small>(PLEASE STATE BELOW)</small> | <input type="checkbox"/> | Psychological distress                                       | <input type="checkbox"/> | Staff support         | <input type="checkbox"/> |
| Assessment   | <input type="checkbox"/> | Emotional distress   | <input type="checkbox"/> | Bereavement care      | <input type="checkbox"/> |
| Rehabilitation   | <input type="checkbox"/> | Spiritual distress   | <input type="checkbox"/> |                       |                          |

**(please describe symptoms, procedure etc)**

**Referred for which service (for service descriptions see back page)**

- |                           |                          |                |                          |                       |                          |
|---------------------------|--------------------------|----------------|--------------------------|-----------------------|--------------------------|
| Triage Telephone Support  | <input type="checkbox"/> | Day Hospice    | <input type="checkbox"/> | Occupational Therapy  | <input type="checkbox"/> |
| Community Palliative Care | <input type="checkbox"/> | Inpatient Unit | <input type="checkbox"/> | Complementary Therapy | <input type="checkbox"/> |
| Hospice at Home           | <input type="checkbox"/> | Physiotherapy  | <input type="checkbox"/> | Other (please state)  | <input type="checkbox"/> |

**FAMILY:**

- Who lives with the patient? (Please state relationship) .....
- Children – please state name/age .....
- Any other relevant information concerning the patient, their family and carers?  
.....

**INSIGHT:**

Is the patient/family aware of this referral?

	Yes	No	
Patient	<input type="checkbox"/>	<input type="checkbox"/>	.....
Family	<input type="checkbox"/>	<input type="checkbox"/>	.....

What is the estimated prognosis? (please circle)      days      weeks      months      years

Is the patient aware of this?	Yes	No	Is the family aware of this?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Patient's priorities for future care

**Where is the patient at present? (Please tick)**

Own Home  Care Home - Nursing  Hospital - Acute  If Hospital please give details  
 Family Home  Care Home - Residential  Hospital - Community  Hospital .....Ward.....  
 Other (PLEASE STATE) ..... Date of planned discharge.....

**Please confirm that patient's G.P. is aware of this referral** Yes  No

**Vulnerabilities/specific needs**

Some people may have specific needs or vulnerabilities – please tick if any of these vulnerabilities apply or give details of any other.

Learning Disability  Dementia  Cognitive Impairment  Significant Mental Health Background   
 Physical Impairment  Sensory Impairment  (Please state e.g. deaf, blind or visually impaired) .....  
 Other (please state) .....  
 Communication Difficulties - Physical  Please state e.g. deaf, aphasia, tracheostomy, other physical condition.....

Is there a key worker involved? Please give the name of the key worker and the organisation involved:.....

**To help us process this referral please give us any other relevant information:**

**PLEASE NOTE THAT REFERRALS RECEIVED BEFORE 11.30 A.M. MONDAY TO FRIDAY WILL BE PRESENTED AT THE REFERRALS MEETING ON THE SAME DAY. REFERRALS RECEIVED AFTER THIS TIME WILL BE DISCUSSED ON THE NEXT WORKING DAY**  
**Relevant letters and discharge summaries should be attached to ensure that the referral can be processed without delay**

We are asked to record the ethnic group of patients to monitor the use of services by our local population, helping to ensure that our services are accessible. We are happy to make any necessary arrangements for patients' needs, for instance for interpreters, dietary preferences or religious needs.

**What is the patient's ethnic group? (Please tick)**

White British		Mixed white/black African		Pakistani		Black African	
White Irish		Mixed white/Asian		Bangladeshi		Other Black	
White other		Other mixed		Other Asian		Chinese	
Mixed white/black Caribbean		Indian		Black Caribbean		Any other Ethnic Group (PLEASE STATE)	

<b>Referred by:</b>	Name: (please print)	Job title:
	Signature:	Date of referral:
	Address: .....	Post Code: .....
	Tel. No: .....	Fax No: .....

## **HOSPICE SERVICES**

### **Triage Telephone Support**

The triage service is provided during the hours of 9.00 – 17.00 each week day. It is the first point of contact from the hospice to patients who have been referred for the triage service or for community palliative care. On receipt of all community referrals a CNS from the triage service will assess for specialist palliative care needs, offer advice and support and then decide which service is appropriate to most meet those needs. Patients who do not require a regular visit from our community palliative care team, but have concerns related to their illness, find our "triage telephone support service" very helpful. This service extends to residents of Barking & Dagenham, Havering and Brentwood.

### **Community Palliative Care Service**

The community palliative care team supports people in the community by providing specialist advice, working in close liaison with a patient's own doctor, district nursing team and other health and social care providers. They provide support for the whole family enabling more patients to remain at home if that is their wish. This service extends to residents of Barking & Dagenham, Havering and Brentwood.

### **Hospice at Home Service**

This team of trained nurses and health care assistants provides care for patients at home in the last 2-3 weeks of life. They work closely with the triage service, community palliative care team, district nurses, Marie Curie carers and social care teams to provide extra professional home support at a critical time. The service extends to residents of Barking & Dagenham, Havering and Brentwood.

### **Day Hospice Service**

The day hospice unit is an integral part of our specialist palliative care service, enabling patients to access the hospice and specialist palliative care teams during regular weekly or fortnightly visits whilst continuing to live at home. With the support of a complex multi-professional team it aims to enhance the independence and quality of life of patients by responding to their physical, psychological, social and spiritual needs. This service extends to residents of Barking & Dagenham, Havering, Brentwood, Redbridge, and local West Essex.

### **Inpatient Unit Service**

The inpatient unit offers specialist palliative care for those patients with the most complex needs associated with any life limiting illness. Admissions can be for assessment, control of symptoms, rehabilitation and end of life care. The key aim is to help patients to get on with living – almost half of all admissions lead to patients returning home. We are unable to provide long term inpatient care, however we would support anyone for whom long term care is required by exploring future care options with them. This service extends to residents of Barking & Dagenham, Havering, Brentwood, Redbridge and West Essex.