

Specialist Palliative Care Community Teams & Inpatient Units across South & West London

<input type="checkbox"/> Greenwich & Bexley Community Hospice Bostall Hill, Abbey Wood SE2 0GB Assessment Coordination Team Tel: 020 8320 5837 Email: gbch.referrals@nhs.net	<input type="checkbox"/> Meadow House Hospice Southall UB1 3HW Tel: 020 8967 5179 Fax 020 8967 5756 Email: referralsmeadowhouse@nhs.net	<input type="checkbox"/> St John's Hospice Grove End Road, St John's Wood NW8 9NH Tel: 020 7806 4040 Fax: 020 7806 4041 Email: Clccg.stjohnsreferrals@nhs.net
<input type="checkbox"/> Guy's & St Thomas' Community Team: Guy's Hospital, Great Maze Pond SE1 9RT Tel: 020 7188 4754 Fax: 020 7188 4748 Email: gst-tr.gstt-palliativecare@nhs.net	<input type="checkbox"/> Michael Sobell House Northwood, Middlesex HA6 2RN Tel: 020 3826 2373/2374 OOH / Inpatient unit: 020 3826 2377 Referrals mob: 07900 228036 Email: msh.enh-tr@nhs.net	<input type="checkbox"/> St Luke's Hospice Kenton Road, Harrow HA3 0YG Tel: 020 8382 8000 Fax: 020 8382 8080 Community Team Fax: 020 8382 8092 Email: LNWH-tr.referralsstlukes@nhs.net
<input type="checkbox"/> Harlington Hospice St Peter's Way, Harlington UB3 5AB Tel: 020 8759 0453 Fax: 020 8759 0600 Email: HILLCCG.harlingtonhospicereferrals@nhs.net	<input type="checkbox"/> Pembridge Palliative Care Centre Exmoor Street, W10 6DZ Tel: 020 8102 5000 Inpatient E-Fax: 03000083207 Comm. Services E- Fax: 0300 008 3206 Email: CLCHT.PembridgeUnit@nhs.net	<input type="checkbox"/> St Raphael's Hospice London Road, North Cheam SM3 9DX Tel: 020 8099 7777 Fax: 020 8099 1724 Sutton CCG referrals to go to: sutccg.raphaelshospicereferrals@nhs.net Merton CCG referrals to go to: merccg.raphaelshospicereferrals@nhs.net
<input type="checkbox"/> Harrow Community Team Kenton Road, Harrow HA3 0YG Tel: 020 8382 8084 Fax: 020 8382 8085 Email: LNWH-tr.HarrowcommunitySPCT@nhs.net	<input type="checkbox"/> Princess Alice Hospice West End Lane, Esher KT10 8NA Tel: 01372 461804 Fax: 01372 470937 Email: SDCCG.clinicaladminpah@nhs.net	<input type="checkbox"/> Royal Trinity Hospice Clapham Common SW4 0RN Tel: 020 7787 1000 Ref & Admissions Nurse: 020 77871065 Fax: 020 7787 1067 Email: rth.referrals@nhs.net
<input type="checkbox"/> Hillingdon Community Palliative Care Team Pield Heath Road, Uxbridge UB8 3NN Tel: 01895 485235 Email: cnw-hchcontactcentrerefs@nhs.net	<input type="checkbox"/> St Christopher's Hospice Lawrie Park Rd, London SE26 6DZ Referral & Admissions Tel. 020 87684582 Email: st.christophers@nhs.net	

For further information and advice on these services, please visit the Hospice UK service directory at: <http://www.hospiceuk.org/about-hospice-care/find-a-hospice> and enter the postcode provided above.

Every hospital has a Specialist Palliative Care team;
if your patient is a *hospital inpatient*, please contact the team, via the relevant hospital switchboard.

FAX MESSAGE

From:	To:
Fax No:	Date:
No. of pages (incl. cover sheet):	
Additional information	
<p>Confidentiality: The content of this fax and attached documents are confidential and intended for the use of the addressee designated above. If you are not the addressee, you are hereby notified that you may not disclose, reproduce or otherwise disseminate or make use of this information for yourself or any third party. If you have received this in error, please notify us on the telephone number given above.</p>	
<p>PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM – including recent clinic letters, blood tests and most recent imaging. NB. INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT</p>	

PATIENT NAME

NHS No.

Essential Patient Details			
Surname	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Patient consent to palliative care involvement? Yes <input type="checkbox"/> No <input type="checkbox"/> Best interest <input type="checkbox"/>
First Name	DoB	Age:	Is GP aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address			
Postcode	Marital Status	Ethnicity	
Tel.	Mob.		
NHS number	Hospital No.		

Primary diagnosis(es)

Communication	Other barriers to communication/registered disabilities:
Fluent in English? Yes <input type="checkbox"/> No <input type="checkbox"/> (If 'no' proceed with remaining questions)	
First Language, if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Next of Kin/Patient Representatives	District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	General Practitioner
Name	Name	Name
Address	Based at	Address
Postcode	Telephone	
Telephone	Fax	
Relationship to patient		Postcode
Main Carer (if different from above)	Social Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Telephone
Name	Name	Fax/Email
Telephone	Based at	CCG:
Relationship to patient	Tel _____ Fax _____	
	Continuing care assessment completed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Continuing care funding agreed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for Referral	Service requested	The patient is currently
Pain/symptom control <input type="checkbox"/>	Home assessment and support. <input type="checkbox"/>	At Home <input type="checkbox"/>
Emotional/psychological support <input type="checkbox"/>	Hospital assessment <input type="checkbox"/>	In Hospital (see over) <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Day Care <input type="checkbox"/>	Other e.g. Nursing Home <input type="checkbox"/>
Assessment for hospice admission..... <input type="checkbox"/>	Outpatient service <input type="checkbox"/>	Please specify
Carer support <input type="checkbox"/>	Admission (<i>delete</i>). <input type="checkbox"/>	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other reason (please give details below). <input type="checkbox"/>	Respite / symptom control / terminal care	
	Hospice at Home <input type="checkbox"/>	

Any access issues (e.g. key safe):

MRSA Status Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/>	Any other communicable infection:
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Special device in situ? Yes No If yes, give details (e.g. trache / PEG / ICD / NIPPV):

Referrer's Name:	Contact number:	Bleep no:
Hospital/Surgery:	This information required on both pages if faxing	

IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/>
IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

In-Patient details		Patient Name:	
Hospital		NHS No:	
Ward	Direct Ward Ext.	Telephone	
Key worker		Date of discharge (if known)	
Consultant		Is Palliative Care team involved? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Brief History of diagnosis(es) and Key treatments		
Date	Progression of disease and investigations/treatment	Consultant and hospital

Current palliative care problems	
1.	4.
2.	5.
3.	6.
Patient Mobility:	Bariatric Nursing required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Any other comments/information (including preferences expressed about care, other psychosocial or spiritual issues or DOLS)

Referrer's expectation of current treatment symptom control / life prolonging / curative

Prognosis: In your opinion, is the patient

Stable? Yes No **Unstable?** Yes No **Deteriorating?** Yes No **Dying?** Yes No

Is death anticipated within: Months Weeks Days

Patient on Coordinate My Care? Yes No Unknown If not, please give reason

On the GSF register? Yes No Unknown **DNACPR in place?** Yes No

Past Medical and Psychiatric History	Current Medication	
		Known Drug Sensitivities/Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Details:

Insight: Has patient been told diagnosis? Yes No **Is the carer aware of patient's diagnosis?** Yes No

Does patient discuss the illness freely Yes No

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature:	Name:	
Job title:	Contact number:	Bleep no:
Surgery or Hospital:	Date:	