The Service User Personal Details below must be checked at every contact with the Service User.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service User - Part 1** | Title | |  | | Forenames | | |  | | | | | | | Surname | | | |  | | | | NHS Number | | | | |  | | | | | |
| SWIFT Identifier | | | | |  | | | | | |
| OASIS Identifier | | | | |  | | | | | |
| Gender | |  | | Age | | |  | | | | DOB | | |  | | | | Preferred Name | | | | |  | | | | | |
| Current  Address | |  | | | | | | | | | | | | Permanent  Address  (if different) | | | |  | | | | | | | | | | | | | | |
| Post Code | |  | | | Phone No | | | |  | | | | | Post Code | | | |  | | | | Phone  No | | | | |  | | | | | |
| Housing  Assoc | |  | Local  Authority | | |  | Owner  Occupier | | | |  | | Private  Rented | | | |  | Live  Alone | | |  | Key  Holder | | | |  |  | | | | | |
| How is access gained to home? | | | |  | | | | | | | | | | | | | Home Hazards | | | | |  | | | | | | | | | | |
| **Service User – Part 2** | Occupation | | |  | | | | Ethnic Category | | | | | | |  | | | | | | | | | | Religion | | | |  | | | | |
| Main Language | | |  | | | | Understands English (Y/N) | | | | | | |  | | Advocate Required (Y/N) | | | | | | |  | | Interpreter Required (Y/N) | | | | | |  | |
| Preferred language | | |  | | | |
| Communication Needs | | |  | | | | | | | | | | | | | | | Home Office Number | | | | | | |  | | | | | | | |
| Is Service User a Carer for a Vulnerable Dependant (Y/N) | | | | | | | | | | | | | |  |
| **Service User – Part 3** | Relevant Medical History | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies | | |  | | | | | | | | | | | | | | | | | | | | | | | Advanced Decision LPA (Y/N) | | | | | |  |
| **GP** | Name | |  | | | | | | | | | | | | | Practice Name | | | |  | | | | | | | | | | | | | |
| Post Code | |  | | | | | | | | | | | | | Phone No | | | |  | | | | | | | | | | | | | |
| **Next of Kin** | Title | |  | | Forename | | |  | | | | | | | | Surname | | | |  | | | | | | Relationship | | | |  | | | |
| Current  Address | |  | | | | | | | | | | | | | Post Code | | | |  | | | | | | | | | | | | | |
| Phone No | | | |  | | | | | | | | | | | | | |
| Emergency  Contact | | | |  | | | | | | | | | | | | | |
| **Carer**  **(if different from NOK)** | Title | |  | | Forename | | |  | | | | | | | | Surname | | | |  | | | | | | Relationship | | | |  | | | |
| Current  Address | |  | | | | | | | | | | | | | Post Code | | | | M | | | | | | | | | | | | | |
| Emergency  Contact | | | |  | | | | | | | | | | | | | |
| **Authorisation** | Is the service user aware of the referral and agrees to participate in information being shared (Y/N) | | | | | | | | | | | |  | | | If No please supply a reason: | | | | |  | | | | | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | Is data protection statement on form (Y/N) | | | | | | | | | | | | | | |  | | |
| Date |  | | | | | | | Time | |  | | | | | Designation | | | | |  | | | | | | | | | | | | |

The information you provide on this form is subject to the provision of the Data Protection Act 1998. It will be used for the purposes of The Provision of Health and Directorate of Adult, Community and Housing Services. We may share this information with any related professionals and providers for the purposes of care management. We are required to collect this information under the powers granted to us by the Community Care Act 1990

Produced for Dudley Health and Social Care Community Version 13 Oct 2013

|  |  |  |
| --- | --- | --- |
| Advice Line: | 01384 321800 | Macmillan_Dudley_St Mary Stevens_RGB.png |
| Fax: | 01384 321524 |  |
| Email: | dgft.dmscah@nhs.net |  |
| Lines open: | 09:00 – 17:00 |  |

**Dudley Palliative Care Referral Form** (Version 6.0)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | Referrers Name | | | | | | | | |  | | | | | | | | | | | |
| NHS No | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Current Location of Patient | | | | Home | | | | | | | | | | | | | Care Home | | | | | | | | | | Referred From | | | | | | | | |  | | | | | | | | | | | |
| Hospital Inpatient:  Ward: | | | | | | | | | | | | | | | | | | | | | | |
| Contact No: | | | | | | | | |  | | | | | | | | | | | |
| Other: (Please State) | | | | | | | | | | | | | | | | | | | | | | | Ward / Dept / Other | | | | | | | | |  | | | | | | | | | | | |
| Is the patient on a GP palliative care register? | | | | Yes | | | | | | | | | | No | | | | | | | | | | | | | Date last seen by referrer | | | | | | | | |  | | | | | | | | | | | |
| **Diagnosis** | | | | | | | | | | | | | | | | | | | | | | | | **Prognosis** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Years** | | | | | | | | | | **Months** | | | | | | | **Weeks** | | | | **Days** | | |
| **Is patient aware of diagnosis?** | | | | | | | | **Yes** | | | | | | | | | | **No** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Carer Support** |  | | | | **End of Life Care** | | | | |  | | | | | **Emotional/ psychological** | | | | | | | | | | | | | | | | | | | | **Respite** | | | | | | | **Social/Financial Support** | | | | | |
| **Symptom Control** |  | | | | **Advance Care Planning** | | | | |  | | | | | **Functional Deterioration** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Specialist Area Required** | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hospice admission** | | | | | | | | | | | | **Macmillan/ Community Team** | | | | | | | | | | | | | | | | | | | | | | | | | | **Psychology** | | | | | | | | | |
| **Day hospice incl. comp therapies** | | | | | | | | | | | | **Hospital Team** | | | | | | | | | | | | | | | | | | | | | | | | | | **Therapies (OT/Physio)** | | | | | | | | | |
| **Is verbal consent gained for referral?** | | | | | | | | | | | | | | | | **Yes** | | | | |  | | | | **No** | | | |  | |  | | | | | | | | | | | | | | | | |
| **Who do we contact to arrange assessment?** | | | | | | | **Patient** | | | | | | **NOK** | | | | | | | | | **Other** | | | | | | | | | | **Please State if other** | | | | | | | | | | | | | | | |
| **Are anticipatory (EOL) meds in place?** | | | | | | | **Yes** | | | | | | **No** | | | | | | | | | **DNACPR?** | | | | | | **Yes** | | | | | | | **No** | | | | | **Has the patient got an ACP?** | | | | **Yes** | | | **No** |
| **Supporting information for referral:**  **Please attach latest scans/consultant letters. Please contact the advice line if you wish to handover further information.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For SPA use only:** | | **Received By** | | | | | | | **Telephone** | | | | | | | | | |  | **Fax** | | |  | | | **Email** | | | |  | | | **Date R’cd** | | | | | |  | | | | **Time R’cd** | | |  | |
| **Receipt confirmed to referrer** | | | | | | | | | | | **New Pt** | | | | | | | | | | | | | | | | | | | | | | | | | | **Existing Pt** | | | | | | | | | | |
| **Services Involved** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Added to Somerset** | | | | | | | | | | | **Added to database** | | | | | | | | | | | | | | | | | | | | | | | | | | **Referrer advised of outcome** | | | | | | | | | | |