CONFIDENTIAL

HOSPICE AT HOME WEST CUMBRIA
HOME NURSING/SUPPORT AT HOME SERVICE
REFERRAL FORM

DATE:	TIME:	REFERRER NAME: POSITION/TITLE:			
Urgency of referral: tick box as appropriate					
URGENT (within 24 hrs)		NON-URGENT (within 2-3 days)		OTHER (please specify)	
PLANNED DATE OF DISCHARGE:					
Is the patient aware of:	Referral	Y / N / NA	Is the carer aware of:	Referral	Y / N / NA
	Diagnosis	Y / N / NA		Diagnosis	Y / N / NA
	Prognosis	Y / N / NA		Prognosis	Y / N / NA
Is the patient/carer agreeable to information being shared with other Health Care Professionals? Y / N					

Patient full name:		Address:	
Preferred name:	Gender: Male/Female/Other		
Tel no:		Post code:	
D.O.B:		NHS NO:	EMIS NO:
Name of next of kin:		Second contact name:	
Relationship:		Relationship:	
Tel No:		Tel No:	
Address:		Address:	

Directions to property/parking/any special instructions: *What 3 words:*	House/Flat/Bungalow:
	Access/Keypad:
Any history of violence or aggression with the patient/family: Y / N	
Does the patient live alone: Y / N	Are there smokers in the house: Y / N

Pets:		
Diagnosis:		
Past Medical History:		
GP:	Practice:	
Number of daily visits and type of care needed:		
Professionals/Agencies involved:	CHC/Fast-track funding confirmed: Y / N	
Patients main carers (none professional) relationship and telephone number:		
Prognosis: Days Weeks Months Unknown		

	YES	NO
Dementia		
Learning Disability		
Karnofsky Score:	Phase of illness: Stable Unstable Deteriorating Dying	

Preference for place of care:	Discussed & Documented: Y / N
Advanced Care Planning:	Discussed & Documented: Y / N
Advance discussion to refuse treatment:	Discussed & Documented: Y / N
DNACPR:	Discussed & Documented: Y / N
EHCP:	Discussed & Documented: Y / N
Mental Capacity assessment undertaken: Y / N	

DOLS in place: Y / N	Best Interests Decision: Y / N	Special CHOC Form: Y / N

Medication Information
Current medication including route at date of referral:
Can patient take medication independently: Y / N *(please give details)*
Syringe Driver: Y / N *(please give details)*
Anticipatory drugs in the house: Y / N *(please give details)*
Waterlow & MUST:
Main Problems *(e.g. mobility, skin, diet, swallowing)*
1.
2.
3.
4.
5.
Equipment in use:
Has the patient been referred to Community Nursing team?: Y / N
Moving and handling assessment (DIAG) in place and on patient's emis record: Y / N

(If no, this will need to be arranged with the Specialist PC OT)	
Document any specific religious/cultural traditions:	
Initial home visit arranged: Review date:	Date:
ANY OTHER INFORMATION/SPECIAL FACTORS TO CONSIDER – Including Advanced Care Planning and Escalation Plan	

To make a referral to Hospice at Home West Cumbria, please complete this form and email it to: adminhahwc@hhwc.cumbria.nhs.uk