**EXTERNAL REFERRAL FORM**

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| **IS REFERRAL URGENT? (Assess within 24/48 hours) Yes: 5 No: 5****IF YES, PLEASE TELEPHONE SERVICE TO DISCUSS - 876555** |
| **Current location of patient:** Home **5**  Nursing Home **5**  Residential Home **5**  Hospital **5**  **Ward name**: |
| **Patient details** |
| **Surname:** | **Tel no:** |
| **Forenames:** | **Title:** | **Does the patient consent to the referral?** **Yes 5 No 5 If no, give reason:** |
| **URN:**  | **DOB:**  |
| **Address:**  | **First contact details:**  |
| **Relationship to patient:** |
| **Tel no:** |
| **Patient agrees to named person being contacted: Yes 5 No 5** |
| **GP and referrer’s details**  |
| GP name | Referrer’s name |
| GP surgery | Referrer’s role |
| GP tel no | Referrer’s tel no |
| If patient in the community is GP agreeable to referral? Yes 5 No 5 | If patient is in hospital is the Consultant/Registrar agreeable to referral ? Yes 5 No 5 |
| **Reasons for referral:**  |
| End of life care **5**   | Emotional/Psychological Support **5** |
| Symptom Control **5**   | Spiritual care/support **5**   |
| **Service requested:**  |
| Outpatient appointment **5**   | Community**/**Home  **5**    |  Home Visit  **5**    |
| Hospital based review **5**   | Hospice admission **5**   |  |
| **GSF code**  | **Blue (A)** **5**Year plus prognosis | **Green (B) 5**Months prognosis | **Amber (C) 5**Weeks prognosis | **Red (D)** **5**Days prognosis |
| **Key Issues requiring Specialist Palliative Care input** |
|  |
| **Diagnosis**  |
|  |
| **Comorbidities/ Relevant Past Medical History** |
|  |
| **Allergies** |
|  |
| **Resuscitation status** |
| Has a discussion regards CPR been undertaken? Yes 5 No 5  | Is DNACPR form in place? Yes 5 No 5  |
| **Treatment Escalation Plan** |
|  |
| **Safeguarding**  |
| Are there any safeguarding issues (nsh abuse or neglect, DOLS)  |
| **Risk Assessments** |
| Please indicate if there are any potential risks or concerns that may affect patient, family or staff safetyeg infections, drug or alcohol misuse, lone worker Yes 5 No 5Reason: |
| **Communication** |
| Language(s): | Is interpreter needed? Yes 5 No 5 |
| **Special Considerations** |
| Please indicate any special considerations eg cultural, ethnic, spiritual, gender, relationships, diet, body image, information sharing |
| **Referrers Name:** | **Signed:** |
| **Date:** |  |