**EXTERNAL REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 5  Reason: | | | | | | | | | | | |
| **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:** | | | |  | | | | | | | |