Please complete all details to ensure your referral is not delayed

Jersey Hospice Care
External Referral Form

Fax: 720292
If faxing ensure both sides are faxed

1. Patient Details	2. GP Details	
Surname: _____ Forenames: _____ Address: _____ _____ Urn: _____ Index No: _____ DOB: _____ Tel No: _____	Name	
	Surgery address	
	Telephone no.	

ADDRESSOGRAPH

3. Name of main contact/patient representative	4. Referred by		
Name: _____ Relationship to patient: _____ Address: _____ _____ _____ Tel no: _____ Are they next of kin: Yes ☐ No ☐	Name		
	Designation		
	Telephone		
	Urgency of response	**Within 24hrs** ☐	**Within 2 days** ☐

5. Where is the patient at present:	Home ☐ Hospital ☐	Nursing Home ☐ **Name of ward:**	Residential Home ☐	
6. GSF Code on referral	**Blue (A)** ☐ Year plus prognosis	**Green (B)** ☐ Months prognosis	**Amber (C)** ☐ Weeks prognosis	**Red (D)** ☐ Days prognosis
7. Communication:	First Language:		Interpreter required: Yes ☐ No ☐	

8. Diagnosis and Co Morbidities:

9. Reason for Referral/Current problems/Past and present relevant treatment, e.g. chemo, radiotherapy
Complex symptom control ☐ Complex psychological issues ☐ End of Life Care ☐
Other/details:

10. Allergies/Sensitivities

Allergy		Reaction	
Sensitivities		Reaction	

11. Infection:	MRSA Yes ☐ No ☐	CDIFF Yes ☐ No ☐	ESBL Yes ☐ No ☐	Other:

12. Current medications: (Please attach supplementary document if necessary)

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13. What is the patient's overall Australian Karnofsky Performance Status		Please tick
100%	Normal, no complaints, no evidence of disease	☐
90%	Able to carry on normal activity, minor signs or symptoms of disease	☐
80%	Normal activity with effort, some signs or symptoms of disease	☐
70%	Cares for self, but unable to carry out normal activity or to do active work	☐
60%	Able to care for most needs, but requires occasional assistance	☐
50%	Considerable assistance and frequent medical care required	☐
40%	In bed more than 50% of the time	☐
30%	Almost completely bedfast	☐
20%	Totally bedfast and requiring extensive nursing care by professionals and/or family	☐
10%	Comatose or barely arousable, unable to care for self, requires equivalent of hospital care, disease my be progressing rapidly.	☐

14. Awareness of diagnosis/prognosis/referral to palliative care:

	Patient			Family /Carer		
Diagnosis	Yes ☐	No ☐	Don't know ☐	Yes ☐	No ☐	Don't know ☐
Prognosis	Yes ☐	No ☐	Don't know ☐	Yes ☐	No ☐	Don't know ☐
Referral	Yes ☐	No ☐	Don't know ☐	Yes ☐	No ☐	Don't know ☐

15. Advance Care Planning: **Only carry out if the patient is ready for the conversation.**

Patients preferred place of care:	1.		2.		
Patients preferred place of death:	1.		2.		
Ceiling of care discussed (give details)					
Advance decision to refuse treatment ADRT completed	Yes ☐	No ☐			
Has DNACPR been discussed with the patient	Yes ☐	No ☐	DNACPR form completed	Yes ☐	No ☐

16. Risks/Concerns - Please indicate if there are any known/potential risks or concerns with the patient/family/carers e.g. alcohol, illicit substance use, violence, safeguarding

17. Please tick relevant box required:

Specialist Palliative Care Team		Hospice In-Patient Admission		King Centre Services	
Clinical Nurse Specialist	☐	Symptom Management	☐	Day Hospice	☐
Medical Outpatient	☐	End of life care (last days)	☐	Physiotherapy	☐
		Crisis Respite	☐	Complementary Therapy	☐
		Palliative Rehabilitation	☐	Lymphoedema Assessment	☐
Pre Bereavement emotional support	☐			The In Control group	☐

For Hospice Use Only – this must be completed for every referral received

GP agreement to referral obtained	Yes ☐	Date	Signature	
Date referral received		**Triaged for urgency of response**	Urgent 24 hrs ☐	Non urgent 2 days ☐

Level of intervention		Please tick
1	Advice and information may be offered to professional colleagues directly. No contact will be made with the patient.	☐
2	JHC professional will make an advisory visit. Such visits will be single, unless requested otherwise by the referrer and further contact will be made by the professional referrer only.	☐
3	JHC may make short term interventions with the patient and their family when specific needs are identified.	☐
4	Ongoing situations with multiple problems requiring continued JHC involvement.	☐
G.P letter sent regarding outcome of the referral		Yes ☐ No ☐