Referral for End of Life Care Beds

Patient Details

NHS No.

Surname: First Name / Known as:

Address:

Post Code: Tel. Home: Mobile:

DOB: Gender:

Current location: ☐ Home ☐ Hospital Ward: ______________________

Date of hospital admission: ______________________ Ward type: : ______________________

Main Diagnosis / Medical Problems	Clinical Needs (e.g. wounds, pressure sores etc.,), consciousness level & ACP to be aware of

Reason for admission to hospital

Admission Request – Criteria for Admission

1. Decision agreed by responsible consultant or senior doctor, if in hospital		2. Does not meet Specialist Palliative Care Eligibility Criteria	
3. Prognosis days to weeks		4. Family and patient (if applicable) know prognosis and eligibility criteria	
5. No reversible causes for deterioration		6. All appropriate treatment stopped e.g. medication	
7. Has DNACPR in place			
8. Mental capacity: ☐ Yes ☐ No If no, has capacity assessment been documented? ________________			
9. Anticipatory medications prescribed		10. Infection status:	
11. On Oxygen? ☐ No ☐ Yes Flow rate ……………. If yes, do supplies need ordering? ________________			
Need specific pressure relieving mattress? ☐ Yes ☐ No Comments …………………………………………..			

Referral for End of Life Care Beds

Patient Name:

Next of Kin

Surname: First Name:

Address:

Post Code: Tel. Home: Mobile:

Relationship

Aware of referral: Yes ☐ No ☐

Professional Details

Known to St Gemma's: ☐ Known to Wheatfields: ☐

GP:

Address:

Tel.:

Hospital Consultant:
(hospital referrals only)

Location:

Other Professionals involved i.e. social workers, JCM:

Referring Person

Name:

Designation: Location:

Tel:

Person Taking Referral

Name (PLEASE PRINT): Signature:

Date: Time:

For office use only:

Admitted: Y ☐ N ☐ Admission Date: ____________ (Delete as applicable) RIP / Discharge / Transfer Date: ____________

Comments: