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| Referral To Leeds Specialist Palliative Care Services |





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| PATIENT DETAILS |  |
| NHS No:  | DOB: Click here to enter a date. | Gender: Please choose |
| Surname: | First Name(s): |
| Address:  | Post Code:  |
| Tel. Home: | Mobile: | Civil State: Choose an item. |
| Religion:  | Ethnic Origin:  | First Language: |
| Patient consented to referral: Yes [ ]  No [ ]   |
|  Referral for: Community Services [ ]  \* Breathlessness Service [ ] **NB** * We triage referrals within 2 working days, for urgent referrals we will aim to respond sooner.
* For **URGENT referrals** or advice regarding potential referrals **please ring the community office**.
* If patient has nursing needs please **also** refer to Neighbourhood team.
* Please ensure you follow the service eligibility criteria if the current need does not meet these referral to the neighbourhood team may be appropriate
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| REASON FOR REFERRAL |  |
| Main Palliative Diagnosis and relevant co-morbidities: |
| Current situation and reason for referral to specialist palliative care – please include current management and options tried: |
| **Palliative Phase:**[ ]  Phase 1: Stable (problems are controlled)[ ]  Phase 2: Unstable (new problems or rapidly increasing severity of problems) [ ]  Phase 3: Deteriorating (on-going deterioration, worsening of existing symptoms or development of new problems)[ ]  Phase 4: Dying (death likely within days) |

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| **Symptom** | **Not at all** **0** | **Slight** **1** | **Moderate****2** | **Severe** **3** | **Overwhelming 4** |
| Pain |  |  |  |  |  |
| Nausea &/orvomiting |  |  |  |  |  |
| Breathlessness |  |  |  |  |  |
| Agitation |  |  |  |  |  |
| Confusion/delirium |  |  |  |  |  |
| Fatigue |  |  |  |  |  |
| Low mood/anxiety |  |  |  |  |  |
| Emotional distress |  |  |  |  |  |
| Family/carer distress |  |  |  |  |  |
| Other (please state) |  |  |  |  |  |
|  |  |  |  |  |  |
| GP PRACTICE |
| Practice Name: |  |
| Address: |  |
| Contact Number: |  |

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| NEXT OF KIN DETAILS |
| Surname: | First Name: |
| Address: | Post Code: |
| Tel. Home: |  | Mobile: |
| Relationship:  | Aware of referral: Yes [ ]  No [ ]  |

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| REFERRING PERSON |  |
| Name:  | Designation:  |
| Location:  | Post Code:  |
| Tel: | Date:  |
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| EMAIL the form to the appropriate palliative care team: |
| St Gemma’s Hospice: neyh.stg.community@nhs.net **Phone 0113 2185540**Registered Charity No. 1015941 Wheatfields Hospice: sryc.cns.wheatfieldshospice@nhs.net**Phone 0113 2787249** Registered Charity No. 1052076 |