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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 &/or  vomiting |  | |  |  | | |  | |  |
| 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: |
|  | | |
| EMAIL the form to the appropriate palliative care team: | | |
| St Gemma’s Hospice: [stg.community@nhs.net](mailto:stg.community@nhs.net)  **Phone 0113 2185540**  Registered Charity No. 1015941  Wheatfields Hospice: [sryc.cns.wheatfieldshospice@nhs.net](mailto:sryc.cns.wheatfieldshospice@nhs.net)  **Phone 0113 2787249**  Registered Charity No. 1052076  ***\*please send all referrals for breathless service to Wheatfields who will then distribute*** | | |