Dr Kershaw's Hospice, Turf Lane.
Royton, Oldham, OL2 6EU

HOSPICE AT HOME REFERRAL FORM

Please email to: drkh.home@nhs.net

We can no longer accept fax referrals. Assistance is available on 07856 514895

PATIENT DETAILS

Surname:		NHS No:	
First Name:		Date of Birth:	
Address:		Gender:	
		Current location of patient:	
Postcode:			
GP Practice:			
For queries who do we contact? (Name, role & tel):			

REASON FOR REFERRAL

We care for patients in the final days of life, generally limited to a 2-week duration so that we remain responsive to urgent palliative care needs.

CARE IN THE FINAL DAYS OF LIFE

(please tick all that apply)

- ☐ In my clinical judgment, I estimate that this patient's prognosis is likely to be very short (two weeks or less).
- ☐ The patient's Preferred Place of Death (PPD) is home.
- ☐ The patient and/or the carer(s) understand the purpose of this referral.
- ☐ A DNACPR decision has been made and the form is with the patient.
- ☐ Potentially futile interventions e.g. tube feeding, TPN, antibiotics etc have been reviewed, involving patient / family.
- ☐ Patient / family are aware that where patients stabilise, we will discharge them from our service.

Please describe the clinical / functional features indicating a very short prognosis:

If you have left any boxes unticked, please give further information here:

MAIN DIAGNOSIS

Primary tumour / non-malignant life limiting illness (with date of diagnosis):

Metastases (if applicable, list all sites):

PAST & PRESENT TREATMENT

Surgery (give dates):

Systemic anti-cancer therapies (chemotherapy / immunotherapy) (give dates):

Ongoing / completed when:

Radiotherapy (list all sites that have been treated) (give dates):

The current treatment intent is: ☐ curative ☐ palliative cancer treatment ☐ best supportive care

The current OACC Phase of Illness is: ☐ stable ☐ deteriorating ☐ unstable
Please leave blank if you are not familiar with OACC ☐ dying (low complexity) ☐ dying (high complexity)

MEDICAL CONTEXT

Significant past medical history:

Please list all current medication (or attach a separate list):

Please list any allergies / intolerances:

Please give the most recent eGFR result (with date):

FUNCTIONAL STATUS

	Tick the single most appropriate vaue	Duration (days)
Comatose or barely rousable.	10 ☐	
Totally bedfast and requiring extensive nursing / personal care.	20 ☐	
Almost completely bedfast.	30 ☐	
In bed more than 50% of the time.	40 ☐	
Considerable assistance and frequent medical care needed.	50 ☐	
Able to care for most needs. Requires occasional assistance.	60 ☐	
Cares for self. Unable to carry on normal activity or do active work.	70 ☐	
Normal activity with effort. Some signs or symptoms of disease.	80 ☐	
Able to carry on normal activity. Minor signs or symptoms of disease.	90 ☐	
Normal. No complaints. No evidence of disease.	100 ☐	
Oral intake	normal ☐ more than mouthfuls ☐ less than mouthfuls ☐	
Delirium	tick if present ☐	
Breathlessness at rest	tick if present ☐	
Generalised oedema	tick if present ☐	

OTHER REQUIREMENTS:

OXYGEN

Please give details of any oxygen therapy including flow rate:

SPECIAL REQUIREMENTS

Please list other requirements (e.g. TPN, NIV, tube feeding etc):

SOCIAL COMPLEXITY

Please give an outline of any social complexity. Describe care package in place (if any):

OTHER PROFESSIONALS INVOLVED	Name / Team / Cluster
☐ District Nurse	
☐ Palliative Care Nurse	
☐ Cancer Nurse Specialist	
☐ Specialist Physio / OT / Dietician	
☐ Acute Oncology	
☐ Enhanced Supportive Care	

DECLARATION
☐ The patient has given consent to a this referral, OR ☐ Where a patient is found to be lacking mental capacity, a suitable process has been followed to establish that Hospice at Home is in the patient's best interest.
☐ The patient / their family are aware of the short prognosis.

REFERRER			
Name of Referrer		Position & Organisation	
Direct Tel No		Date	

This form does not require a signature.