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

INPATIENT UNIT REFERRAL FORM

Please complete each section clearly and concisely. If you need more space, please use the additional sheet provided.

Please email to: drkh.inpatients@nhs.net

We can no longer accept fax referrals. Assistance is available on 0161 785 5600.

PATIENT DETAILS

Surname:		NHS No:	
First Name:		Date of Birth:	
Address:		Gender:	
		Current location of patient:	
Postcode:			
GP Practice:		CCG:	

If your patient is not registered with an Oldham or Manchester GP, you will need to apply for funding. Please phone on the above number to discuss.

For any referral queries, or to arrange admission, who do we best contact? (Give name, role & tel no):

REASON FOR REFERRAL

We admit patients for care in the final days of life, for complex pain and symptom control challenges and for rehabilitation.
Inpatient treatment is generally limited to a 2-week duration so that we remain responsive to urgent palliative care needs.
We are not commissioned to provide respite care or medium / long term care.
We no longer "hold" referrals so please only complete this form if you want your patient to be admitted now.

Please complete Section A, B or C to indicate what your patient's needs are:

☐ A. 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 the Hospice.
- ☐ The patient and/or the carer(s) understand the purpose of this hospice admission.
- ☐ A DNACPR decision has been made and the form will be sent with the patient on admission.
- ☐ 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 make appropriate discharge arrangements.

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

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

☐ B. COMPLEX PAIN AND SYMPTOM CONTROL

Please list in reasonable detail what your patient's pain and symptom control needs are:

Please indicate what makes you feel that these needs are best met in an inpatient setting:

Please give an overview of any treatments that have been helpful so far:

Please give an outline of what treatments haven't been useful and whether this was due to lack of effect or poor tolerability:

For the benefit of continuity, have you had any particular treatments in mind that you felt the Hospice should explore?

Any other comments?

☐ C. REHABILITATION

Rehabilitation in palliative care can be successful where a patient had a recent acute and significant loss of function. This might be e.g. after cancer treatment or following an intercurrent illness.

What is your patient's usual baseline state?

What is his / her current level of functioning?

Please state what your patient's rehabilitation goals are:

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):

If you require more space to provide medical details, please use the Additional Information sheet provided. Ensure that all relevant information is included to assist in your care.

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 indicate what makes you feel that these needs are best met in an inpatient setting:

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 ☐	

ADDITIONAL INFORMATION

If you require more space to provide medical details, relating to section A, B or C please use this Additional Information sheet.

Please ensure that all relevant information is included to assist in the patient's care.

Please note that there is an Other Requirements section on the next sheet.

OTHER REQUIREMENTS:

OXYGEN

Please give details of any oxygen therapy including flow rate:

You will need to submit a HOOF order prior to admission (please consider that delivery takes a minimum of 4 hours)

ENHANCED CARE (1:1) / DOLS

Has your patient required enhanced care (1:1) or similar? Or has a DOLS been in place? Please give details:

INFECTION RISK

Is your patient considered an infection risk (MRSA, CPE, C.DIFF etc)? Please give details:

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 hospice admission, OR ☐ Where a patient is found to be lacking mental capacity, a suitable process has been followed to establish that hospice admission is in the patient's best interest.
☐ The patient / their family agree that this will be for a maximum of 2 weeks.
☐ The patient accepts that smoking is not permitted on the Hospice premises.

REFERRER			
Name of Referrer		Position & Organisation	
Direct Tel No		Date	

This form does not require a signature.