

# HOSPICE AT HOME REFERRAL FORM

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

**Please email to: [drkh.home@nhs.net](mailto: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 inc  
Postcode:

Gender:

Current  
location of  
patient:

Tel No:

Next of Kin (Name  
& contact details)

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):

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## 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)

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

## 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 |
|-------------------------------------------------------------|-----------------------|
| <input type="checkbox"/> District Nurse                     |                       |
| <input type="checkbox"/> Palliative Care Nurse              |                       |
| <input type="checkbox"/> Cancer Nurse Specialist            |                       |
| <input type="checkbox"/> Specialist Physio / OT / Dietician |                       |
| <input type="checkbox"/> Acute Oncology                     |                       |
| <input type="checkbox"/> Enhanced Supportive Care           |                       |

## ADDITIONAL INFORMATION

If you require more space to provide medical details, relating to the above sections, please use this Additional Information sheet. Please ensure that all relevant information is included to assist in the patient's care.

| DECLARATION              |                                                                                                                                                                   |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | The patient has given consent to a this referral, <b>OR</b>                                                                                                       |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | The patient / their family are aware of the short prognosis.                                                                                                      |

| REFERRER         |                      |                         |                      |
|------------------|----------------------|-------------------------|----------------------|
| Name of Referrer | <input type="text"/> | Position & Organisation | <input type="text"/> |
| Direct Tel No    | <input type="text"/> | Date                    | <input type="text"/> |

This form does not require a signature.