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|  | **Kilbryde Hospice Inpatient Referral Form** |  |
| McGuinness Way, Hairmyres, East Kilbride, G75 8GJTelephone: 01355 202020 Fax 01355 279616 | | |
|  | | |
| Inpatient Referrals are reviewed Monday – Friday mornings; if the Patient requires an emergency admission please call the Hospice and ask for the on-call Doctor. Once complete – please email to **kilbrydehospice.referrals@lanarkshire.scot.nhs.uk** | | |

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| **1.Personal Details** | | | | | | | |
| Surname |  | | Forenames |  | | | |
| Address |  | | | | | | |
|  |  | | | | | | |
| Postcode |  | | Telephone Number |  | | | |
| Gender | Male | Female | Ethnicity |  | | | |
| Age |  | | CHI number |  | | | |
| Date of Birth | /  / | | Relationship status |  | | | |
| Has the patient given consent for the referral? | Yes | No | If No, does the patient lack capacity?  (Adult with Incapacity (Scotland) Act 2000) | Yes | | No | |
|  |  |  | If the patient lacks capacity, has a Certificate of Incapacity been completed? | Yes | | No | |
| Has the patient been provided with written information about the Hospice? | Yes | No | *Information Booklets are available from the Hospice or can be viewed or downloaded from Hospice website.* | | | | |
| Does the Patient Smoke? | Yes | No | Have you made the patient aware of the No Smoking Policy at the Hospice? | | Yes | | No |

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| **2.Contact Details** | | | | | |
| Name of Next of Kin |  | | Relationship to Patient |  | |
| Address |  | | | | |
|  |  | | | | |
| Postcode |  | | Home Phone number |  | |
| Does the patient live alone? | Yes | No | Mobile Phone Number |  | |
| Is the Next of Kin aware of the referral? | Yes | No | Who should initial contact be with? | Patient | Next of Kin |
| Name of General Practitioner |  | | Address |  | |
|  |  | |  |  | |
|  |  | | Post Code |  | |
| Contact Number |  | | Email Address |  | |

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| **3.Current Care** | | | | | | | | | | | | |
| Is the patient known to Kilbryde Hospice? | | Yes | | No | | Staff or Service Name (If Known) | | | | | | |
| Where is the Patient currently? | | |  | | | | Other: | | | | | |
| *Complete this section if the patient is currently in Hospital* | | | | | | | | | | | | |
| Hospital Name: |  | | | | Under the Care Of: | | | | | |  | |
| Ward Name: |  | | | | Contact Number: | | | | | |  | |
| Does the patient currently have the services of any of the following? | | Hospital Palliative Care Nurse | | | Community MacMillan Nurse | | | | District Nurse | | | Other Nurse Specialist |
|  | |  | | |  | | | |  | | |  |
| Name of Nurse | |  | | |  | | | |  | | |  |
| Contact Details | |  | | |  | | | |  | | |  |
| Give details of any current Care Package | |  | | | | | | | | | | |
| Social Work Contact | |  | | | | | | Telephone No: | |  | | |

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| **4.Principle Reason for Inpatient Referral (Please Select)** | | |
| **Symptom Control** | **Rehabilitation** | **End of Life Care** |
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| **5.Medical Information**  *Please note medical staff at Kilbryde Hospice do not have ready access to patients Hospital or Community Notes* | | | | | | | | | | | | | | |
| Main Diagnosis |  | | | | | Date of Diagnosis | |  | | | | | | |
| Indications of Advanced Disease: (e.g. metastatic disease, performance status, O2 dependence, etc.) | | | | | | | | | | | | | | |
| Past Medical History : | | | | | | | | | | | | | | |
| Relevant Investigation Results: | | | | | | | | | | | | | | |
| Does the patient currently have a DNACPR in place? | | Yes | No | Additional info about DNACPR Discussions : | | | | | | | | | | |
| Has the patient been fitted with a pacemaker? | | Yes | No | Does the patient have any radioactive implants? | | | | | | Yes | | | No | |
| Has the patient ever tested positive for MRSA? | | Yes | No | Additional information about MRSA history: | | | | | | | | | | |
| Is the patient aware of their diagnosis? | | Yes | No | Are the patient’s family/next of kin aware of the diagnosis? | | | | | | | | Yes | | No |
| Is the patient aware of their likely prognosis? | | Yes | No | Are the patient’s family/next of kin aware of the likely prognosis? | | | | | | | | Yes | | No |
| Mobility- please describe the patients level of mobility | | Independently mobile | | | Mobile with a walking aid | | Mobile with assistance | | | | Immobile | | | |
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| Allergies or Intolerances | | Medicines | | | | Food | | | Other | | | | | |
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| **Relevant Treatments or Interventions (e.g. surgery, radiotherapy, systemic anti-cancer therapy, NIV, PEG, etc)** |
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| **Current Clinical Issues** |
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| **Current Family/Social Issues Relevant to this Referral** |
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| **6.Current Symptoms** | | | | | | |
|  | **None** | **An Occasional Problem** | **Moderate Problem** | **Severe Problem** | **Very Severe**  *(Can’t Think Of Other Matters)* | **Cannot Be Assessed** |
| **Pain** |  |  |  |  |  |  |
| **Nausea/Vomiting** |  |  |  |  |  |  |
| **Dyspnoea** |  |  |  |  |  |  |
| **Bowel Disturbance**  *(please describe below)* |  |  |  |  |  |  |
| **Confusion** |  |  |  |  |  |  |
| **Patient Distress** |  |  |  |  |  |  |
| **Family Distress** |  |  |  |  |  |  |
| **Other symptom information** |  | | | | | |

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| **7.Current Medication** | | | | | |
| **Medicine** | **Dose** | **Frequency/prn** | **Date Commenced** | **Indication** | **Response**  **(if relevant)** |
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| **Other Relevant Medication History** | | | | | |
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| Does the patient have a clinical need for a : | Family Room | Please state clinical need: |

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| **9.Referrer Information**  ***Referrals will not be considered without GP (Community Patients) or Consultant (Hospital Patients) permission*** | | | | |
| Has GP/Consultant approval been given for this referral | Yes | No | Name of GP/Consultant |  |
| Name of Referrer |  | | | |
| Designation |  | | | |
| Address |  | | | |
| Telephone Number |  | | | |
| Mobile Telephone Number |  | | | |
| Email Address |  | | | |
| Date of Referral |  | | | |

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| **(For Office use only)** | | | | | |
| **Patient referral registered on CrossCare** | | Date    /  / | Patient known to Hospice/Notes available? | Yes | No |
| **Patient Presented at Daily Admission Meetings** | | Date    /  / | | | |
| **Outcome** | Added to Waiting List | Offered Bed | Inappropriate referral | Other(Please state) | |