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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 |
|  | [ ]  | [ ]  | [ ]  | [ ]  |
| 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** |
|       |
| **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)       |