**Sheffield Teaching Hospitals**

**NHS Foundation Trust**

| **Sheffield Specialist Palliative Care Referral Form** | | | | |
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| **PATIENT** Surname: | First name(s): | | Hospital No: | |
| Date of birth: Age: | NHS No: | | | |
| Address: | Gender: | | | |
| Marital/civil status: | | | |
| Ethnic origin: | | | |
| Telephone: | Religion: | | | |
| ReSPECT plan in place? YES  NO | CPR attempts recommended YES  NO | | | |
| Recommendation for emergency care  Prioritise extending life  Balance extending life with comfort and valued outcomes  Prioritise comfort. | | | | |
| Is an interpreter required? YES  NO  If yes, which language? | Infection status: | | | |
| Current location of patient: | Occupation: | | | |
| Is patient consenting to referral, including sharing of medical information? YES  NO  Does not have capacity to consent | Is consultant/GP aware of referral? YES  NO | | | |
| If patient does not have capacity to consent to referral has there been a documented BIM (please attach a copy of this to the referral)? YES  NO | | | | |
|  |  | | | |
| **1st CONTACT** Name: | **2nd CONTACT** Name: | | | |
| Relationship: | Relationship: | | | |
| Address: | Address: | | | |
| Telephone: | Telephone: | | | |
| Is this person the next of kin? YES  NO | Is this person the next of kin? YES  NO | | | |
|  |  | | | |
| **GP** Name: | **CONSULTANTS** Name and location: | | | |
| Address:  Telephone: |
|  |  | | | |
| Palliative Care Hospital Support Team (NGH)  Palliative Care Outpatient Clinic (NGH)  Sheffield Macmillan Unit for Palliative Care Admission | Email:  [**sth.palliativecareadmin@nhs.net**](mailto:sth.palliativecareadmin@nhs.net) | | | or phone  22 **66770** |
| Palliative Care Hospital Support Team (RHH/WPH)  Palliative Care Outpatient Clinic (RHH/WPH) | Email:  [**sth.palliativecareadmin@nhs.net**](mailto:sth.palliativecareadmin@nhs.net) | | | or phone  22 **65602** |
| St Luke's Hospice: Inpatient Centre Admission (please also complete A+D score overleaf)  Integrated Community Team  Patient & Family Support Service | Email:  [**SLHOS.clinicaladministration@nhs.net**](mailto:SLHOS.clinicaladministration@nhs.net) | | | or phone  236 9911 |
|  |  | | | |
| **PALLIATIVE DIAGNOSIS: ESTIMATED PROGNOSIS:**  **Current treatment focus: Curative :**  **Palliative:**  **No further treatment:** | | | | |
| Patient aware of diagnosis? YES  NO  Patient aware of prognosis? YES  NO | | | | |
| Relevant medical history**:** | | | | |
|  | | | | |
| **CURRENT MEDICATION INFORMATION, please include on separate sheet if needed:** | | | | |
| Allergies: | | | | |
|  | | | | |
| **What prompted you to send this referral today?** | | | | |
| **URGENT**  **ROUTINE**  **This will be reassessed at triage call.** | | | | |
| **SYMPTOM CONCERNS** including how long these symptoms have been present (e.g. does the patient have pain, SOB, what has been done to manage this concern so far): | | | | |
| **SOCIAL CONCERNS** (i.e. complex family/lives alone, what has been done to help with this so far): | | | | |
| **PSYCHOLOGICAL CONCERNS** (i.e. coping/ high level distress, what has been done to help with this so far): | | | | |
| **SPIRITUAL CONCERNS** (i.e. fear of death, faith needs, what has been done to help with this so far): | | | | |
|  | | | | |
| **REFERRED BY:** | | Post: | | |
| Contact no:  Please include surgery bypass number or mobile number. | | Date of referral: | | |
| NHS email address | |  | | |
| **We are unable to process this referral without complete information. If information is missing the referral will be returned and your patient’s care may be delayed.** | | | | |