**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** | or phone 22 **66770** |
| Palliative Care Hospital Support Team (RHH/WPH) [ ] Palliative Care Outpatient Clinic (RHH/WPH) [ ]  | Email:**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** | or phone 236 9911 |
|  |  |
| **PALLIATIVE DIAGNOSIS: ESTIMATED PROGNOSIS:****Current treatment focus: Curative :** [x]  **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.** |