**The Norfolk Hospice Tapping House Referral Form**

**Completed Forms to Be Emailed to: norfolk.hospice@nhs.net**

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| **PATIENT DETAILS** | | | | | | | | | | | | | | | |  | | **GP DETAILS** | | |
| Surname: |  | | | | | | | | | First Name: | | |  | | |  | | Name: |  | |
| DOB: |  | | | | | | | | | NHS No.: | | |  | | |  | | Address: |  | |
| Address: |  | | | | | | | | | | | | | | |  | |
|  | |
| Postcode: |  | |
| Home Tel: |  | | | | | | | | Mobile: | | | |  | | |  | | Postcode: |
| Other Tel: |  | | | | | | | | Other Tel Name: | | | |  | | |  | | Tel No: |  | |
| Interpreter required? | Yes |  | | No | | |  | | First Language: | | | |  | | |  | | E-mail: |  | |
| Current Place of Residence | | Home | | | | | | | Care Home | | | | Hospital | | Other |  | |  | | |
| **NEXT OF KIN DETAILS document if none** | | | | | | | | | | | | | | | | | | | | |
| Relationship to Patient: | | | | |  | | | | | | | | | Name: | | |  | | | |
| Home Tel: | | | | |  | | | | | | | | | Address: | | |  | | | |
| Mobile: | | | | |  | | | | | | | | |
| **MAIN CARER DETAILS (if Different to Next of Kin)** | | | | | | | | | | | | | | | | | | | | |
| Relationship to Patient: | | | | |  | | | | | | | | | Name: | | |  | | | |
| Home Tel: | | | | |  | | | | | | | | | Address: | | |  | | | |
| Mobile: | | | | |  | | | | | | | | |  | | | |
| **CLINICAL SUMMARY OF PATIENT’S CONDITION** | | | | | | | | | | | | | | | | | | | | |
| *Please include current main diagnosis, treatments, etc:*  *What is important for us to know, to best meet the needs of the patient and their family? What outcome are you hoping for? Patient/family understanding of disease/prognosis* | | | | | | | | | | | | | | | | | | | | |
| *Please note any equipment required e.g. oxygen/bariatric etc* | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | **Details** | | | | | | | | |
| Is the patient felt to be in the last year of life? | | | Yes | | |  | | No | | |  |  | | | | | | | |  |
| Does the patient have a Respect Document? | | | Yes | | |  | | No | | |  |  | | | | | | | |  |
| Is the patient able to travel to outpatient appointments? | | | Yes | | |  | | No | | |  |  | | | | | | | | |
| Please specify reasons and requirements | | | | | |  | | | | | | | | | | | | | | |

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| **SERVICE(S) REQUIRED (Please tick those required)** | | | | |
| **Tulip Centre (Day Therapy Services) (Response within 7 days).** The Tulip Centre is open to anyone with a palliative condition regardless of prognosis. We offer short-term 1-1 and group interventions with a focus on rehabilitation and improving quality of life. We use non-pharmacological interventions to address both physical and psycho-social symptoms which are impacting on day to day life. We will provide an introduction to wider palliative services and the hospice. | | | |  |
| **Palliative Social Work Referral (Response within 7 days).**  The Social Work team offers support with social complexity, assessing care needs and emotional and psychological family support. |  | Please give further details: | | |
| **Inpatient Admission.** An inpatient admission is either for end of life care estimated to be less than 6 weeks prognosis or for a symptom management admission. |  | **Hospice at Home to support dying at home for the last six weeks of life.** Patients need a valid DNACPR/ReSPECT document and anticipatory medications in place. Assessment will be made by a registered nurse to determine the level of input required and to ensure a referral to the hospice is appropriate at this time. |  | |

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| **PATIENT CONSENT (referrer details)** | | | | |
| **I confirm the following:**  I have discussed the referral to the hospice for support with either symptom management, end of life care, psychosocial and/or therapeutic support and the patient has consented and understands that The Norfolk Hospice Tapping House may need to access the relevant information on their GP record. The patient is aware that they will be contacted by a member of staff from the hospice. If the patient lacks capacity to consent to the referral to the hospice, the referral must be made in the Best Interest of patient in conformance with the Mental Capacity Act. | | | | |
| Name: |  | | Role: |  |
| Tel No: |  | | Date: |  |
| Mental Capacity Assessment Date (if applicable) | |  | | |
| Best interest Decision Maker Name (if applicable) | |  | | |
| LPA for Health & Welfare (if applicable) | |  | | |
| LPA for Property & Financial Affairs (if applicable) | |  | | |

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| **ADDITIONAL PATIENT INFORMATION** | | | | | | | | | | | | |
|  | Is there any reason to doubt the persons capacity to make: | | | | | | | | | | | Details |
| **Mental Capacity** | Simple day to day decisions | | | | | | Yes |  | | No |  |  |
| Complex decisions about treatment & care? | | | | | | Yes |  | | No |  |  |
| **Safeguarding Concerns** | | Yes |  | No |  | Additional Info: | | |  | | | |
| **Infection Issues** | | Yes |  | No |  | Additional Info: | | |  | | | |
| **Communication Difficulties** | | Yes |  | No |  | Additional Info: | | |  | | | |
| **Any Other Considerations** | | Yes |  | No |  | Additional Info: | | |  | | | |

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| **COMPLETE THE FOLLOWING SECTION FOR REFERRALS TO INPATIENT/HOSPICE AT HOME** |

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| **THE FOLLOWING SECTION IS FOR INPATIENT/HOSPICE AT HOME ADMISSIONS ONLY**  **URGENCY OF THE REFERRAL. Please note acceptance is subject to clinical need and capacity** | | | | | |
|  | Within 24 hours (please call 01485 601700 to discuss) |  | Within 48-72 hours |  | Within 7 days |

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| **CEILING OF TREATMENT DISCUSSED AND AGREED WITH PATIENT AND FAMILY *– Please Tick*** | | | |
|  | **1** | **Intensive** | Transfer to hospital if appropriate. Intubation, ventilation etc. should be considered |
|  | **2** | **Hospital** | Transfer to hospital for treatment if appropriate, DNACPR in place |
|  | **3** | **Home** | Treatment, medication and comfort measures within the community with support from GP.  Admission to hospital would be avoided unless comfort measures fail |
|  | **4** | **Comfort** | For comfort measures only.  Admission to hospital would be avoided unless comfort measures fail [e.g. Fracture neck of femur] |

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| **END OF LIFE INFORMATION** | | | | | | | | |
| DNACPR Form Completed: | | | Yes | |  | No |  |  |
| Preferred Place of Care: | | |  | | | | | |
| Preferred Place of Death: | | |  | | | | | |
| In your opinion, can this patient be safely looked after in a normal bed, in a unit with a maximum of 3 nursing staff and no overnight medical cover? | | | | | | | | |
| Yes |  | No |  | If the answer is no, please call 01485 601700 to discuss | | | | |

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| **Any additional comments:** |

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| **OFFICE INFORMATION ONLY** | | | | | |
| Date/Time Initial Referral: |  | If incomplete Date/Time sent back to referrer: |  | Date/time received back: |  |
| Time seen by/discussed with appropriate clinician: |  | If declined date/time letter/discussion with referrer and rationale |  | If accepted date/time 1st contact with patient and plan |  |