Palliative Care Register and Care at Home Referral Form - Part 1 (Mandatory)

Consent and knowledge			
	Diagnosis	**Prognosis**	**Referral***
Is the patient* aware of?			
Is the relative aware of?			

PLEASE NOTE PATIENT MUST BE AWARE OF AND CONSENTING TO REFERRAL BEFORE PROCEEDING UNLESS THEY LACK CAPCACITY AND REFERRAL IS BEING MADE IN PATIENTS BEST INTERESTS

Patient Details			
Name		**Date of Birth**	
NHS Number		**Current Location**	
Home Address		**Discharge address (if different from Home address)**	
Home Contact No		**Discharge Address Contact No**	
GP Name		**GP Address**	
Next of Kin Name		**Next of Kin contact No**	
Date of discharge;		**CCG:**	

Clinical Details	
Confirmed Diagnosis of Life limiting illness	
Phase of illness	**Stable/Unstable/Deteriorating/Dying**
Karnofsky Index	**https://www.hospicepatients.org/karnofsky.html**
Prognosis	

Any metastasis?			
RNT Level		**RNT Score**	
What is the patient's resuscitation status at time of referral?			

Reason for requesting referral?

	Yes	No
Are there any other health conditions?		
Are there any known infections?		
Does the patient have a ReSPECT Form?		
Has the patient got a signed ADRT?		
Are there any communication problems?		
Have there been any concerns regarding decision making?		
Is there any challenging behaviour?		
Does the patient have continence issues?		
Has an advance care plan been completed?		
Does the patient have complex needs, psychological or symptomatic?		
Is the patient or any member of the household suspected or confirmed to have COVID19?		
Does the patient have anticipatory medication in the home?		

If you answered yes to any of the above questions, please give further details here

Referrer Details			
Date of Referral		**Time of Referral**	
Name		**Contact Number**	
Job Title			

	Yes	No
Is the patient mobile?		
Does the patient live alone?		

Please tick which service(s) you would like your referral to be forwarded to	✓
LCHS Community Nursing	
LCHS Macmillan	
St Barnabas Community Hospice	
Marie Curie Rapid Response	
Local Neighbourhood Team	

Important Guidance Notes

If GP referring, please ensure a share of patient records has been actioned.

Is this referral for physio and OT?
Yes: Complete **section 1 and 2.**
No: Complete **section 1 only.**

Does this referral require a CHC Fast Track funding application for care in the community?
Yes: Complete **section 1,2 and 3 and email** to necmid.pcccreferrals@nhs.net and lccg.ft@nhs.net

Does this referral also require a CHC Fast Track funding application for care in a Nursing or Residential Home?
Yes: Complete section **1,2 and 3 and email to** lccg.ft@nhs.net

Part 2 – Packages of care/Nights/Physio/OT referral only

Brief reason for request for emergency package

Care Requested	**Needs Assistance**	**Needs Full Care**	**Independent**	**Details must be given for ALL areas where care is required**
All aspects of personal care				
Breathing				
Nutrition				
Continence				
Skin				
Mobility Please include if hoist is required				
Communication				
Psychological & Emotional				
Cognition				
Behaviour				
Drug Therapies & Medication				
Altered States of Consciousness				

Current nursing home or care agency details (if applicable)
Private Carers ☐ **Agency care package** ☐
Nursing Home Placement Yes ☐ No ☐
Please give number of hours provided in current package:

CARE AGENCY PACKAGE	**No. of Hrs and Arrival Time per visit** Each box completed must show both length of call and number of carers required						
Tick days care required	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Am							
Lunch							
Tea							
Bed							
Waking Night							
Sleeping Night							
Total Hours							

Specific Requirements:	**Yes**	**No**	**Details must be given for ALL applicable fields**
Female carer accepted	☐	☐	
Male carer accepted	☐	☐	
Keycode / Assisted Technology?	☐	☐	**Do not include key code number**
Will family / friend let the carer in?	☐	☐	
Are there any pets?	☐	☐	
Does anybody in the household smoke?	☐	☐	
Is Life Line available?	☐	☐	
What facilities are available to carer? (ie place to rest, kitchen , toilet, phone)	☐	☐	
Specific directions or parking details?	☐	☐	
Other	☐	☐	

Part 3: Application for CHC Fast Track Funding

Fast Track Pathway Tool for NHS Continuing Healthcare

To enable immediate provision of a package of NHS Continuing Healthcare

The individual fulfils the following criterion:

He or she has a rapidly deteriorating condition and the condition may be entering a terminal phase. For the purposes of Fast Track eligibility this constitutes a primary health need. No other test is required.

Brief outline of reasons for the fast-tracking recommendation:

Please set out below the details of how your knowledge and evidence of the patient's needs mean that you consider that they fulfil the above criterion. This may include evidence from assessments, diagnosis, prognosis where these are available, together with details of both immediate and anticipated future needs and any deterioration that is present or expected.

(continue overleaf)

Please continue on separate sheet where needed. This should include the patient's name and NHS number, and also be signed and dated by the referring clinician.

I, an appropriate clinician, confirm that I have explained to the individual/their representative (tick as appropriate):

the reasons why a Fast Track application for NHS Continuing Healthcare has been made to the CCG. ☐

that the purpose of this is to enable the individual's needs to be urgently met as they have a rapidly deteriorating condition which may be entering a terminal phase. ☐

that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review ☐

Please ensure this form is sent directly to the CCG without delay

Name and signature of referring clinician	**Date**

Name and signature confirming approval by CCG	**Date**

About you — equality monitoring

Please provide us with some information about yourself. This will help us to understand whether people are receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex?
Tick one box only

☐ Male
☐ Female
☐ In another way
☐ I prefer not to answer

2 Which age group applies to you?
Tick one box only

☐ 18-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75-84
☐ 85+
☐ I prefer not to answer

3 Do you have a disability as defined by the Equalities Act 2010?
Tick one box only.

The Equalities Act 2010
Defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

☐ No
☐ Yes
☐ I prefer not to answer

4 What is your ethnic group?
Tick one box only.

A White
☐ English / Welsh / Scottish / Northern Irish / British
☐ Irish
☐ Gypsy or Irish Traveller

☐ Any other White background, write below
Click here to enter text.

B Mixed / Multiple ethnic groups
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed / Multiple ethnic background, write below
Click or tap here to enter text.

C Asian / Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Any other Asian background, write below
Click here to enter text.

D Black, or Black British
☐ African
☐ Caribbean
☐ Any other Black / African / Caribbean background, write below
Click here to enter text.

E Other ethnic group
☐ Arab
☐ Any other ethnic group, write below
Click here to enter text.

Prefer not to say
☐ I prefer not to answer

5 What is your religion or belief?
Tick one box only.

Christian includes Church of England/Wales/
Scotland, Catholic, Protestant and
all other Christian denominations.

☐ None
☐ Christian
☐ Buddhist
☐ Hindu
☐ Jewish
☐ Muslim
☐ Sikh
☐ Prefer not to answer
Any other religion, write below
Click here to enter text.

6 Which of the following best describes your sexual orientation?
Tick one box only.

☐ Heterosexual or Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Prefer not to answer
Other, write below

Reminder of Guidance Notes

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