Weldmar Hospicecare
Caring for Dorset

REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE

All referrals received are triaged within 24 hours Monday – Friday

**** For URGENT admission to Joseph Weld Hospice please telephone 01305 215300 – in all other circumstances please complete this referral form in full**

ELIGIBILITY CRITERIA
Essential: • The patient has an advanced progressive medical condition that indicates they have a life expectancy of 1 year or less **Plus one or more of the following needs that cannot be adequately addressed by the current care team:-** • The patient has complex symptom management problems. • The patient and/or their significant others have psychological, social or spiritual needs relating to their advanced progressive medical condition.
WHO MIGHT BENEFIT FROM SPECIALIST PALLIATIVE CARE INPUT
Anyone with an advanced progressive illness may need the input of specialist palliative care when **complex** physical and/or psychosocial needs arise for the patient or their significant others. Advanced progressive illness may include cancer, end stage heart failure, COPD or pulmonary fibrosis, MND or PSP, end stage renal or liver failure. We can support children (with appropriate parental/guardian consent) and families of Weldmar patients pre- and post-bereavement.

PATIENT DETAILS			
Patient's Name & Title: Known as:	Patient's Address: Post code:	Telephone Number: Date of Birth:	
Current location of patient:	NHS Number:	Hospital Number:	
Patients must be aware of and agree to the referral. If patients lack capacity to consent, referral must be judged to be in their best interests. Patient aware of referral Yes ☐ No ☐			Gender:
Name of significant other:	Relationship to patient:	Contact number:	
Address (if different to the patient):	Is this person aware of the patient's diagnosis/prognosis? ☐ Yes ☐ No If not, please give more information		
Please give details of any risk factors to be aware of when visiting this patient:			
Referred by (Name & Designation):	Contact number:	Signature & date:	

Patient's Name: **Date of Birth:**

OTHER PROFESSIONALS INVOLVED (name and phone number)	
Patient's GP & surgery telephone number: The patient's GP will be informed Is GP aware of referral? Yes ☐ No ☐	
Consultant(s):	
CNS/Community Matron:	District Nurses:
Social Services:	Others (e.g CRT, DAIRS):

DIAGNOSIS	
Diagnosis: Metastases: Other medical conditions: Other relevant information (e.g. psychological/social issues):	Is patient aware of: Diagnosis: Yes ☐ No ☐ Prognosis: Yes ☐ No ☐ If no, please give details:

ADVANCE CARE PLANNING

Is the patient on the GSF Register? Yes ☐ No ☐ If yes, what colour coding?

Where is the preferred place of death? Home ☐ Care Home ☐ Hospice ☐ Community Hospital ☐ Acute Hospital ☐ Unknown ☐

Is a DNACPR/AAND in place? Yes ☐ No ☐ If yes, please send a copy with referral

CURRENT PROBLEMS OR NEEDS

Symptom control ☐ Psychological support ☐ Carer support ☐ or other ☐

Specific reasons for referral - please be clear about the issues that require our involvement.

Which of our core services do you feel to be most appropriate for the patient initially?

Specialist Community Nursing Services ☐ Day Services ☐
Outpatient Appointment ☐ MND Specialist Service ☐
(from diagnosis if appropriate)

PLEASE SEND COMPLETED FORM & SUPPORTING DOCUMENTATION (e.g. GP summary including current medication list, relevant recent clinic letters & scan reports, DNAR) to weldmar.referrals@nhs.net or fax to 01305 263321

PLEASE ENSURE THAT ALL RELEVANT INFORMATION HAS BEEN PROVIDED TO AVOID A DELAY IN PROCESSING THIS REFERRAL