



Referral Form

Clinical Admin Use:
 HCAS No
 Request recorded on S1

Date of Contact	Time of Contact
------------------------	------------------------

Patient details: Name Current Location NHS NUMBER Address/Tel No	DOB: GP
--	--------------------

Referrer	
Name	Designation
Contact details	
SYSTEMONE RECORD – THIS PATIENT HAS GIVEN VERBAL CONSENT FOR OVERGATE TO	
SHARE IN:	YES <input type="checkbox"/> NO <input type="checkbox"/>
SHARE OUT:	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diagnosis	

NEW REQUIRED INFO	
Has the pt or a member of their family developed a new continuous cough or high temperature? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Covid Status?: Positive swab <input type="checkbox"/> Negative Swab <input type="checkbox"/> Suspected <input type="checkbox"/> Not suspected <input type="checkbox"/>	
Is the patient having / will they need Aerosol Generating Procedures? E.g	
Suction <input type="checkbox"/>	Tracheostomy <input type="checkbox"/>
CPAP <input type="checkbox"/>	NIV/NIPPV <input type="checkbox"/>
High flow Nasal O2 <input type="checkbox"/>	BiPAP <input type="checkbox"/>
Cough Assit <input type="checkbox"/>	Invasive Ventilation <input type="checkbox"/>
For Covid +ve: Is the patient aware they are not for further escalation of care? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Is the pt/family aware there may be Covid19 +ve pts in the hospice currently? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Is the pt/family aware of the restrictions on visiting? (see Overgate website) YES <input type="checkbox"/> NO <input type="checkbox"/>	

Reason for referral/contact	
Inpatient admission	Does the patient agree to admission? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Does the patient have capacity to consent to admission? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Urgency? Same day <input type="checkbox"/> Next day <input type="checkbox"/> Routine <input type="checkbox"/>
	Reason for Admission? Symptom Control <input type="checkbox"/> Terminal Care <input type="checkbox"/> Psychological Support <input type="checkbox"/> Other <input type="checkbox"/>
	HOOF required YES <input type="checkbox"/> NO <input type="checkbox"/>
	DNAR in place YES <input type="checkbox"/> NO <input type="checkbox"/>
	Infection YES <input type="checkbox"/> NO <input type="checkbox"/>
	Does the patient have any pressure damage? YES <input type="checkbox"/> NO <input type="checkbox"/> Area/s affected Grade <input type="checkbox"/>
Does this patient smoke? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Day Hospice <input type="checkbox"/> Dementia Service – Time to Think Pass information to a Senior Member of Day Hospice Staff <input type="checkbox"/>	

Current care arrangements/provision at home	
Problems prompting referral	
Assessed recently by SPCT <input type="checkbox"/>	Life limiting illness <input type="checkbox"/>
Uncontrolled Pain <input type="checkbox"/>	Psychological/spiritual issues <input type="checkbox"/>
Other uncontrolled symptoms, please specify below	
Has this patient expressed a preferred place of death? Home <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/>	
Have you informed the pt/family of the current hospice visiting policy? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Does this patient have any specialist needs, e.g. tracheostomy, specialist equipment, spiritual, dietary, language/ interpreter? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Details	

Referral Information

Additional Comments

Signed:

Date:

Reason for delay	Patient chooses to wait <input type="checkbox"/>	Staffing issues at Overgate <input type="checkbox"/>	Other <input type="checkbox"/>
	No beds at Overgate <input type="checkbox"/>	Transport <input type="checkbox"/>	

ADMISSION ARRANGEMENTS			
Does the pt need a single room?		YES	NO
Date patient to be admitted to Overgate			
Above agreed by (Overgate Doctor)	Name	Date	Time
Above agreed by (Overgate Nurse)	Name	Date	Time
Admission date offered to referrer by:	Name	Date	Time
<i>REFERRER ASKED TO:</i>	<i>INFORM PATIENT ARRANGE TRANSPORT IF NECESSARY ARRANGE OXYGEN IF NECESSARY</i>		
IPU Whiteboard updated			
Ward Clerk informed			
On Waiting List in Referral Folder			
SystemOne Status updated to "on Waiting List"			
Same Day Admissions only:	Inform Reception Inform Housekeeping Inform Catering		
Admission arranged by			