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|  | **Referral Form** | **Clinical Admin Use:**  HCAS No ………………………….  Request recorded on S1 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of contact** |  | |  | **Time of contact** | |  |
|  | | | | | | |
| **Patient** | | | | | | |
| Name | |  | | | DOB: | |
| Current Location | |  | | | GP | |
| **NHS NUMBER** | |  | | |
| Address/Tel No | |  | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer** | | | | | | | | |
| Name | |  | | | | Designation |  | |
| Contact details | |  | | | |  |
| **SYSTMONE RECORD** – THIS PATIENT HAS GIVEN VERBAL CONSENT FOR OVERGATE TO | | | | | | | | |
| SHARE IN: | YES | |  | NO |  | | |  |
| SHARE OUT: | YES | |  | NO |  | | |  |

|  |  |
| --- | --- |
| **Diagnosis** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Reason for referral/contact** | | | | | | | | | | | | | | | | | | | | | |
|  | **Inpatient**  **admission** | | **Does the patient agree to admission?**  **Does the patient have capacity to consent to admission?** | | | | | | | | | | YES  YES | |  | NO | |  | | |  |
| **Urgency?** | Same day | | | |  | Next day | | |  | | Routine | | | |  | |  | |
|  | | | **Reason for admission?** | Symptom  control | | | |  | Terminal  Care | | |  | | Psychological  support | | |  | | Other | | |
|  | | | **HOOF required?** | | Yes  No |  | **DNAR in place?** | | | Yes  No |  | | **Infection?** | | | Yes  No | |  | | | |
|  | | | **Does the patient have any pressure damage?** | | | | | | | Yes  No |  | | Area/s affected  Grade | | | | |  | | | |
|  | | | **Does this patient smoke?** | | | | | | | Yes |  | | | | | No | |  | | | |
|  | | **Day Hospice** | **Dementia Service – Time to Think** Pass information to a Senior Member of Day Hospice Staff | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Current care arrangements/provision at home** | | | | | | |
| **Problems prompting referral** | | |  | |  | |
| Assessed recently by SPCT | Life limiting illness | Uncontrolled Pain | | Psychological/spiritual issues | | Other uncontrolled symptoms  please specify below |
| |  |  | | --- | --- | | **Has this patient expressed a preferred place of death?** | Home  Hospice  Hospital  Nursing Home |   **Does this patient have any specialist needs, e.g. tracheostomy, specialist equipment, spiritual, dietary, language/ interpreter? YES/NO**  **Details ……………………………………………………………………………………………………………………** | | | | | | |
| **Referral Information** | | | | | | |
|  | | | | | | |

|  |
| --- |
| **Additional Comments**    **Signed:**  **Date:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Reason for delay** | Patient chooses to wait |  | Staffing issues at Overgate |  | Other |  |
| No beds at Overgate |  | Transport |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **ADMISSION ARRANGEMENTS** | | | |
| **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** |
| *REFERRER ASKED TO:* | *INFORM PATIENT*  *ARRANGE TRANSPORT IF NECESSARY*  *ARRANGE OXYGEN IF NECESSARY* |  |  |
| **IPU Whiteboard updated** | |  |  |
| **Ward Clerk informed** | |  |  |
| **On Waiting List in Referral Folder** | |  |  |
| **SystmOne Status updated to “on Waiting List”** | |  |  |
| **Same Day Admissions only:** | **Inform Reception** |  |  |
|  | **Inform Housekeeping** |  |  |
|  | **Inform Catering** |  |  |
| **Admission arranged by ………………………………………………………..** | |  |  |

Updated 06 October 2018