|  |  |
| --- | --- |
| **Marie Curie Referral formal**  Logo  Description automatically generated  **Referrer name** (Registered Professional):  **Role:**  **Contact details:**  **Name** if completing on behalf of registered professional:  Please complete **all sections** to ensure the patient can be registered and enable Marie Curie to provide care as requested. | |
| **Patient Registration** | |
| **Primary details** | |
| **Title** |  |
| **Given name** (First Name) |  |
| **Known as** |  |
| **Family name** (Surname) |  |
| **Gender** |  |
| **Date of Birth** (dd/mm/yyyy) |  |
| **NHS number** |  |
| **Religion** |  |
| **Marital status** |  |
| **Ethnicity** |  |
| **Main language**  If other than English, is an interpreter needed? Y/N |  |
| **Patient’s contact details** | |
| **Full address** including postcode |  |
| **Access instructions** e.g. key safe code |  |
| **Home number** |  |
| **Mobile number** |  |
| **District Nurse details** | |
| **Name** |  |
| **In hours contact number** |  |
| **Out of hours contact number** |  |
| **GP details** | |
| **Title** |  |
| **GP practice name & address** |  |
| **What service** are you referring to? |  |
| **Next of Kin details** | |
| **What is their relationship to the patient?** |  |
| **Title** |  |
| **Family name** (Surname) |  |
| **Given name** (First Name) |  |
| **Home number** |  |
| **Mobile number** |  |
| **Are they an emergency contact?** Y/N |  |
| **Can we discuss the patient’s record with this individual?** Y/N |  |
| **Are they a Carer?** Y/N |  |
| **If no, and there is a Carer, please provide details.** |  |
| **Coordination Referral Templates** | |
| **Registration Diagnosis** (for reporting) | |
| **Do they have Cancer or Non-Cancer?** |  |
| **What is their diagnosis?** |  |
| **Referral Base Notes** | |
| **Locality** (geographical) |  |
| **Is the patient in the last 12 weeks of life?** Y/N/Not sure |  |
| **Is there a Care Plan in the Home?** Y/N/Not sure |  |
| **What is the location of patient at Referral?** |  |
| **Who does the patient live with?** |  |
| **What package of care are you requesting?**  Days & nights/days only/night sits only |  |
| **Number of days** (if applicable) |  |
| **Number of nights per week** |  |
| **HCA/RN required** |  |
| **Advance care planning** | |
| **Has a DNACPR decision been made?** |  |
| **If yes, is it a ReSPECT or DNAR?** |  |
| **If yes, what is their Resuscitation status?** |  |
| **Where is it kept?** |  |
| **What is the Preferred Place of Care?** |  |
| **What is the Preferred Place of Death?** |  |
| **What is the priority of care level?** Please refer to the Appendix at the end of this form to make assessment. |  |
| **Clinical information** | |
| **What are the main symptoms at present?** Tick and detail as appropriate. |  |
| **Pain** |  |
| **Respiratory illness or problems** |  |
| **Nausea** |  |
| **Vomiting** |  |
| **Appetite issues** |  |
| **Constipation** |  |
| **Are there consciousness issues?** Please detail. |  |
| **Any known allergies?** |  |
| **Is the patient aware of diagnosis?** Y/N/Not sure |  |
| **Are the family aware of diagnosis?**  Y/N/Not sure |  |
| **Any other significant health problems?** |  |
| **Patient prognosis?** |  |
| **Is the patient aware of prognosis?**  Y/N/Not sure |  |
| **Are the family aware of prognosis?**  Y/N/Not sure |  |
| **Is the Carer aware of prognosis?**  Y/N/Not sure |  |
| **Is the patient able to consent to treatment and care?**  Y/N/Not sure |  |
| **Have any hazards been identified in the vicinity of the property?**  For example, lighting/parking/walking/stairs. |  |
| **Does patient have any cognitive or other types of impairment?** Please detail. |  |
| **Is there a Prescription for Palliative Care anticipatory Medicine?**  Y/N/Not sure |  |
| **Is there a syringe driver?**  Y/N/Not sure |  |
| **Home Oxygen supply?**  Y/N/Not sure |  |
| **Accessible Communication** | |
| **Any visual impairment** If yes, please detail. |  |
| **Any difficulty communicating?**  Please detail, for e.g. hearing aids, sign language. |  |
| **Carers communication needs**  Please detail, for e.g. hearing aids, sign language. |  |
| **Home Visit Risk Summary** | |
| **Has a patient handling risk assessment been carried out?**  Y/N/Not sure |  |
| **Any history of falls?**  Y/N/Not sure |  |
| **Are there any pets in the home?** If yes, please detail. |  |
| **Does smoking take place in the home?** Y/N/Not sure |  |
| **Any physical environmental hazards that could affect safe care delivery?** If yes, please detail. |  |
| **Are supplies required by the care and handling plan in the house?**  For example, gloves, aprons, hoists, etc. |  |
| **Infection control** | |
| **Does the patient have suspected Covid19?** Y/N |  |
| **Does anyone in the home have suspected Covid19?**  Y/N |  |
| **Any patient AGP?**  Y/N |  |
| **Any household AGP?** Y/N |  |
| **Continence summary** | |
| **Any urinary or faecal incontinence?** Y/N/Not sure |  |
| **Any continence management aids in place?** Y/N/Not sure |  |
| **Catheter in use?**  Y/N |  |
| **Are incontinence pads used?** Y/N/Not sure |  |
| **Patient handling** | |
| **Any diet and fluid requirements?** If yes, please detail. |  |
| **Hospital bed or mattress in place?**  Y/N |  |
| **What is the patient’s current mobility?** |  |
| **Has a recent skin assessment been undertaken?** Y/N |  |
| **Does their behaviour alter/is there risk of aggression?** If yes, please detail. |  |
| **Do you have any further comments?** |  |

**APPENDIX A**

Please use the following categories to assess the patient’s **priority of care level.** (This assessment should be made by the District Nurse).

