**Homeless Specialist Palliative Care Support Service Project - MDT referral form**

This form is a guide to some of the questions you may be asked upon referral. Please call to make a telephone referral if you do not have access to an NHS email account as it will not be secure to send patient information. For any queries or to make a referral call 01803 210811.

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| **Patient details:** | |
| Mr/Mrs/Ms/Miss/Mx/Other: | Preferred Pronouns: |
| Surname: | Forenames: |
| Known as: | First Language: |
| DOB: | NHS Number: |
| Current Address or where can be found: | Phone Number: |
| Any lone working or safety concerns: |
| **Diagnosis / Medical History:** | |
| Diagnosis and past medical history if known: | |
| Please list (if known) drugs patient taking prescribed or recreational: | |
| Patient insight into situation (if known): | |
| ***Referral Criteria:***   1. ***The patient is 18 years or over and residing in the Rowcroft catchment area.*** 2. ***The patient has consented to the referral.*** 3. ***The patient has known end stage disease/deteriorating ill health and a limited prognosis.*** | |
| **Reason for referral: (please tick)** | |
| Support with symptom management: *Please specify what the issues are:*    Support with planning ahead/ethical decision making  Support with emotional/psychological needs (not acute mental health need)  Support for staff e.g., training, practicalities of care, general advice. | |
| **Referrer details:** | |
| Name: | Designation/Role: |
| Place of work: | Contact details:  Tel -  Email - |
| Patient/client aware of referral? Yes No  If no, please explain why – | |
| Any concern regarding mental capacity? | |
| **Other agencies involved/health professionals/key people:** | |
| GP Name (if known): | GP Practice Address:  Phone Number: |
| Support Worker Name(s): | Phone number:  Email: |
| Other Health professionals involved in care (if known):  Name(s): | Phone number:  Email: |
| Key Hospital contact e.g., Oncologist/Specialist/Nurse (if known)  Name(s): | Phone number:  Email: |
| Next of Kin or significant other details (if known):  Name(s): | Phone number:  Email: |
| Drug and Alcohol Worker (if applicable)  Name: | Phone number:  Email: |
| Social Worker (if applicable)  Name: | Phone number:  Email: |

**Please email form to:** [**R-H.communityteam@nhs.net**](mailto:R-H.communityteam@nhs.net) **if using a secure NHS email account. Thank you.**

**If you do not have an NHS email, please contact 01803 210811 to complete these questions verbally.**