**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.***
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|  **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** **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.**