EAST LANCASHIRE HOSPICE
INFORMATION TO SUPPORT PROVISION OF HOSPICE AT HOME SERVICES
INITIAL / REVIEW

Please complete this risk assessment form in addition to the generic referral form provided			
Surname:	M ☐	NHS No:	Marital Status:
First Name:	F ☐	Religion:	Ethnic Group:
Patient address:			
Tel. No:		Mobile No:	
Next of Kin:		Relationship:	
Next of kin address (if different to patient):		Next of Kin Telephone:	
Emergency contact Name		Emergency Contact Telephone:	
Can information regarding your care and condition be shared with this person? **Yes** ☐ **No** ☐			
District Named Nurse:		Tel No:	
Fax No:		Mobile:	
Base:		Team:	

Reason for Referral: Last Days of Life ☐ Complex Discharge ☐ Health care Support ☐
Social Support ☐ Carer Support ☐

Additional Questions:		
	Yes (Details)	No
Is the patient aware of their diagnosis/ Prognosis?		
DNAR in place/ in the property?		
District Nurse care plan in the property?		

Patients main problems/ priorities to be addressed by hospice at home services

Property Details:				
Type of property:	House	Bungalow	Flat	Other?
Are there any issues finding the property?				
Are there any issues with access to property?				
Are there any issues regarding parking facilities at property or nearby?				
Are there any issues regarding maintaining the security of the property?				
Are there any circumstances that would result in a risk of fire at the property				
Are there any people that the patient does not want to visits them?				
What pets are located at the property, are there any considerations that need to be known to minimise risk?				
Telephone access- **Is there a landline in the property?** **Is there suitable mobile phone signal?**				
Which rooms does the patient occupy, are there any rooms that the patient is at risk in or that the HCA cannot access?				
Are there any other risks that may impact on staff providing services				
Facilities for staff use				

Emergency information	
Location of water stop tap	
Location of Fuse box	
Location of Gas shut off point	
Other (specify)	
Other (specify)	

Details of other services/ professionals involved in care:		
	Name:	Contact information:
Private care company:		
Social worker:		
Marie Curie:		
Clinical Nurse specialist:		
Complex case manager:		

Falls Screening information		
Has the risk of falls been identified?	Yes – Details	No
Has the patient experienced any falls in the last 12 months?	Yes – Details	No
Has referral been made for a falls assessment?	Yes – Details	No

Complete the section below and specify need

H.C.A. ☐

Hospice at Home will offer a maximum of 3 nights cover by a H.C.A. (availability permitting)
Please tick which 3 nights are preferred if known.

Start Date:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Volunteer Sitter ☐

Hospice at Home can offer 3 hour slots during the day. (availability permitting)
Please tick which day is preferred if known.

Start Date:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Referrer details	
Referrer Name:	
Contact telephone number:	
Relationship to patient:	
Date of referral:	

Please return this form with the referral form

This information will be scanned and saved to the patient's EMiS notes and will be used by staff and volunteers visiting the patient

This information will not be retained in the patient's home