PALLIATIVE CARE - INPATIENT UNIT REFERRAL FORM

Email to: admin.eastlancashirehospice@nhs.net
Tel Numbers for Clinical Administration:
01254 916983/965864

Admission to the Inpatient Unit can be considered for patients with a life limiting illness requiring specialist palliative care that cannot be delivered at home. This means general palliative care options have been exhausted and there is:

- a complexity of symptoms causing significant distress that are not responding to current care pathways.
- a level of complexity that is not able to be managed within community setting.
- A need for care in the last days/week of life when symptoms are uncontrolled.
- or the hospice is the patient's preferred place of death.

Most admissions are planned – we are not an emergency service. We prioritise allocation of beds according to the patient's needs so it is important that you fully complete all sections as referrals will be triaged to determine priority. The detail in your information regarding the patient's condition and the issues you want us to address will support this process. You must exclude potentially reversible acute medical problems that may account for your patient's deterioration before referring your patient as these may need hospital intervention. Please note that we are unable to offer inpatient respite care.

Where there are no complex needs at the present time or needs/symptoms are being managed please consider if the patient would benefit from a referral to other professionals/services including, for example, District Nurses, Hospice at Home, Fast Track, Care setting.

<table>
<tr><td>Circle M / F</td><td>Title</td><td>First Name</td><td>Last Name</td><td>Preferred Name</td></tr>
<tr><td colspan="2">Date of Birth</td><td>Hospital Number</td><td>NHS Number</td><td rowspan="2">GP Name & Practice</td></tr>
<tr><td colspan="3" rowspan="3">Address

Post Code</td><td>Telephone Number</td></tr>
<tr><td>Mobile Number</td><td>Referrer Name (Please print)</td></tr>
<tr><td>Patient Location at time of referral</td><td>Referrer Base & Role</td></tr>
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Patient Diagnosis and Medical History

Describe how your patient's complex needs mean that an IPU admission is required at this present time.
Current problems/symptoms. Examples are pain, agitation/confusion, breathing, nausea & vomiting, emotional distress, carer distress.

Treatments/ Medication for presenting symptoms:
What has been tried?

What medication is currently prescribed?

What medication/dose and how many PRNs required in past 48hrs

Does the patient have capacity to consent to this referral? (circle): **YES** **NO**
If YES, sign here to confirm that the patient consents to the referral:
If NO, sign here to confirm that the decision to refer is in the patient's best interests:
Note: we cannot accept a referral for a patient who has capacity and does not consent

Does the patient have (please tick and provide details):

Any Safeguarding concerns		
Communication difficulties		
DOLS in place		
Any complex wounds/pressure damage		
Preferred place of care		
Preferred place of death		
A DNACPR order in place		
An Advance Care plans.		
Just-in-case Medications/ Anticipatory Medications		
Care Package		

Date of completion:

Signature of referrer: