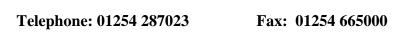
EAST LANCASHIRE HOSPICE HOSPICE AT HOME RISK ASSESMENT FORM





Please complete the risk assess:	ment for	m <u>in ad</u>	<u>dition</u> to	o the generic referra	l form provided						
Surname:	M NHS No: Marital State										
First Name:	F 🗌	Religion: Ethnic G									
Next of Kin:	Next of Kin: Relationship:										
Name:				1							
Address:											
Tel. No: Mobile No:											
Can information regarding you	r care an	d condi	tion be	shared with this per	son? Yes	No					
District Named Nurse:											
Base:											
Tel No:											
Mobile:		1	1								
		Yes	No	How will staff gain	n access to hom	e?					
Does the patient live alone?											
Is the patient aware of referral?											
Is family/carer aware of referral? Keypad No:											
Reason for Referral: Last Days of Life											
Additional Questions		Yes	No								
Is the patient aware of the diagram											
Is the patient aware of the prog											
Is the patient for resuscitation											
Is the patient a research particip	oant (rec	ord stud	ly)								
Is there community documentation				•	_						
Have any risks been identified	within th	ne home	enviro	nment eg smoking,	any pets etc.						
Details:											
Are Social Services involved				Base:							
Social Worker's Name:											
Contact No:											
Is Marie Curie Involved	mla aa	D	ate of re	eferral:							
Is any formal care provision in Details:	prace										
Is a Community Matron involv	ed										
	Base:		Co	ontact No:							
Is a Clinical Nurse Specialist in	Base:		Co	ontact No:							

Does the patient have any problems with:		Yes No		Details							
Pressure areas											
Pain											
Elimination											
Other Symptoms		+									
Wounds											
Risk of infection eg	MDSA										
Hygiene Hygiene	MINSA	+									
Mobility (if yes is there	equipment										
available in the home to											
Breathing											
Eating/drinking											
Medicine manageme	ent										
Communication											
Emotional state											
Meeting social needs	S										
		<u>'</u>		•							
Details of facilities	for staff witl	hin the h	ome:	:							
Toilet											
Heating											
Telephone access											
Is protective clothing a	available if										
applicable											
Is appropriate seating available											
for the carers shift											
Complete the section below and specify the most appropriate person to deliver the care											
Complete the section below and specify the most appropriate person to deniver the care											
H.C.A.											
_											
Hospice at Home wi	ll offer a max	ximum of	f 3 ni	ghts cover by	a H.C.A. (a	vailability	permitting)				
Please tick which 3 i	nights are pre	eferred if	know	vn.							
							_				
Start Date:	Monday	Tuesda	y V	Vednesday	Thursday	Friday	Saturday	Sunday			
_	_										
Volunteer Sitter L											
	00 01										
Hospice at Home car			_	the day.							
Please tick which da	y is preferred	1 if know	n.								
C44 D-4	Mondov	Tuesde	., \	Vodnosdov	Thursday	Friday	Caturday	Cundov			
Start Date:	Monday	Tuesda		Wednesday	Thursday	Friday	Saturday	Sunday			
	am	am		ım	am	am	am	am			
	pm	pm		om	pm	pm	pm	pm			
Referrer Name:				Design	ation/Base:						
Meletter rame. Designation/Dase.											
Contact Telephone No: Date and time of referral:											

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