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| **Part 1 - Palliative Care Register and Care at Home Referral Form (Mandatory)** |

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| **1.1 Consent and knowledge** |
|  | **Diagnosis** | **Prognosis** | **Referral\*** |
| **Is the patient\* aware of?** | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  |
| **Is the relative aware of?** | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  |

**\*PLEASE NOTE PATIENT MUST BE AWARE OF AND CONSENTING TO REFERRAL BEFORE PROCEEDING UNLESS THEY LACK CAPACITY AND REFERRAL IS BEING MADE IN PATIENTS BEST INTERESTS\***

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| **1.2 Patient Details** |
| **Name** |  | **Date of Birth** |  |
| **NHS Number** |  | **Current Location** |  |
| **Home Address** |  | **Discharge address (if different from Home address)** |  |
| **Home Contact No** |  | **Discharge Address Contact No** |  |
| **GP Name** |  | **GP Address** |  |
| **Next of Kin Name** |  | **Next of Kin contact No** |  |
| **Date of discharge** |  | **ICB** |  |

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| **1.3 Clinical Details including need for aerosol generating procedures (AGP)**  |
| **Confirmed Diagnosis of Life limiting illness** |  |
| **Phase of illness (**[**click here**](https://www.kcl.ac.uk/cicelysaunders/attachments/studies-oacc-brief-introduction-booklet.pdf)**, p.8)** | Choose an item. |
| **Karnofsky Index (**[**click here**](https://www.kcl.ac.uk/cicelysaunders/attachments/studies-oacc-brief-introduction-booklet.pdf)**, p.10)** (choose the appropriate percentage according to the scale provided) | Choose an item. |
| **Prognosis** |  |
| **Any metastasis?** |  |
| **Is the patient or any member of the household suspected or confirmed to have COVID19?** | **YES** [ ] **Provide details:** | **NO** [ ]  |
| **RNT Level (**[**click here**](https://www.eolc.co.uk/professionals/palliative-care-coordination-centre-referral-pccc-spa)**)**  | Choose an item. | **RNT Score** | Choose an item. |
| **What is the patient’s resuscitation status at time of referral?** | **YES – to be resuscitated** [ ]  **NO – not for resuscitation** [ ]  |
| **Type of AGP care need and frequency of intervention** |

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|  | YES | Frequency |
| Open suctioning of the respiratory tract (including the upper respiratory tract) | [ ]  |  |
| Tracheotomy or tracheostomy procedures (insertion or open suctioning or removal) | [ ]  |  |
| Non-invasive ventilation (NIV) | [ ]  |  |
| Bi-level Positive Airway Pressure Ventilation (BiPAP) | [ ]  |  |
| Continuous Positive Airway Pressure Ventilation (CPAP) | [ ]  |  |
| Induction of sputum | [ ]  |  |
| High flow nasal oxygen (HFNO) > 45L/min | [ ]  |  |

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| **1.4 Reason for requesting referral?** |
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| **1.5 Further details** | **YES** | **NO** |
| Are there any other health conditions? | [ ]  | [ ]  |
| Are there any known infections? | [ ]  | [ ]  |
| Does the patient have a ReSPECT Form? | [ ]  | [ ]  |
| Has the patient got a signed ADRT? | [ ]  | [ ]  |
| Are there any communication problems? | [ ]  | [ ]  |
| Have there been any concerns regarding decision making? | [ ]  | [ ]  |
| Is there any challenging behaviour? | [ ]  | [ ]  |
| Does the patient have continence issues? | [ ]  | [ ]  |
| Has an advance care plan been completed? | [ ]  | [ ]  |
| Does the patient have complex needs, psychological or symptomatic? | [ ]  | [ ]  |
| Is the patient mobile? | [ ]  | [ ]  |
| Does the patient live alone? | [ ]  | [ ]  |

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| **1.5.1** If you answered yes to any of the above questions, please give further details here |
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| **1.6 Referrer’s Details** |
| **Date of Referral** |  | **Time of Referral** |  |
| **Name**  |  | **Contact Number** |  |
| **Job Title** |  |

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| **1.6.1 Please tick which service(s) you would like your referral to be forwarded to** | ✓ |
| LCHS Community Nursing | [ ]  |
| LCHS Macmillan | [ ]  |
| St Barnabas Community Hospice | [ ]  |
| Marie Curie Rapid Response | [ ]  |
| Local Neighbourhood Team | [ ]  |

**Important Guidance Notes**

**If GP referring, please ensure a share of patient records has been actioned.**

**Is this referral for physio and OT?**

**Yes:** Complete **part 1 and 2.**

**No:** Complete **part 1 only.**

**Does this referral require a CHC Fast Track funding application for care in the community?**

**Yes****:** Complete **part 1,2 and 3 and email** to pcccgeneral&referrals@stbarnabashospice.co.uk and licb.ft@nhs.net

**Does this referral also require a CHC Fast Track funding application for care in a Nursing or Residential Home?**

**Yes:** Complete part **1,2 and 3 and email to** licb.ft@nhs.net

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| **Part 2 – Packages of care/Nights/AHP referral only** |

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| **2.1 Brief reason for request for emergency package** |
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| **2.2 Care Requested** | **Needs Assistance** | **Needs Full Care** | **Independent** | **Details must be given for ALL areas where care is required** |
| All aspects ofpersonal care | [ ]  | [ ]  | [ ]  |  |
| Breathing | [ ]  | [ ]  | [ ]  |  |
| Nutrition | [ ]  | [ ]  | [ ]  |  |
| Continence | [ ]  | [ ]  | [ ]  |  |
| Skin | [ ]  | [ ]  | [ ]  |  |
| MobilityPlease include if hoist is required | [ ]  | [ ]  | [ ]  |  |
| Communication | [ ]  | [ ]  | [ ]  |  |
| Psychological & Emotional | [ ]  | [ ]  | [ ]  |  |
| Cognition | [ ]  | [ ]  | [ ]  |  |
| Behaviour | [ ]  | [ ]  | [ ]  |  |
| Drug Therapies & Medication | [ ]  | [ ]  | [ ]  |  |
| Altered States of Consciousness | [ ]  | [ ]  | [ ]  |  |

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| **2.3 Current nursing home or care agency details (if applicable)**  |
| **Private Carers** [ ]  **Agency care package** [ ] **Nursing Home Placement YES**  [ ]  **NO**  [ ] Please give number of hours provided in current package: |

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| **2.4 CARE AGENCY****PACKAGE** | **No. of Hrs and Arrival Time per visit**Each box completed must show both length of call and number of carers required |
| **Tick days care required** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| Am |  |  |  |  |  |  |  |
| Lunch |  |  |  |  |  |  |  |
| Tea |  |  |  |  |  |  |  |
| Bed |  |  |  |  |  |  |  |
| Waking Night |   |   |   |   |   |   |   |
| Sleeping Night |   |   |   |   |   |   |   |
| Total Hours |  |  |  |  |  |  |  |

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| **2.5 Specific Requirements:** | **Yes** | **No** | **Details must be given for ALL applicable fields** |
| Female carer accepted |[ ] [ ]   |
| Male carer accepted |[ ] [ ]   |
| Keycode / Assisted Technology? |[ ] [ ]  **Do not include key code number** |
| Will family / friend let the carer in? |[ ] [ ]   |
| Are there any pets? |[ ] [ ]   |
| Does anybody in the household smoke? |[ ] [ ]   |
| Is Life Line available? |[ ] [ ]   |
| What facilities are available to carer? (i.e. place to rest, kitchen, toilet, phone) |[ ] [ ]   |
| Specific directions or parking details? |[ ] [ ]   |
| **Other** |[ ] [ ]   |



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| **Part 3: Application for CHC Fast Track Funding** |

**Fast Track Pathway Tool for NHS Continuing Healthcare**

To enable immediate provision of a package of NHS Continuing Healthcare

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| **The individual fulfils the following criterion:**He or she has a rapidly deteriorating condition and the condition may be entering a terminal phase. For the purposes of Fast Track eligibility this constitutes a primary health need. No other test is required.  |
| **Brief outline of reasons for the fast-tracking recommendation:**Please set out below the details of how your knowledge and evidence of the patient’s needs mean that you consider that they fulfil the above criterion. This may include evidence from assessments, diagnosis, prognosis where these are available, together with details of both immediate and anticipated future needs and any deterioration that is present or expected. |
|  **(continue overleaf)** |
| *Please continue on separate sheet where needed. This should include the patient’s name and NHS number, and also be signed and dated by the referring clinician.* |

**I, an appropriate clinician, confirm that I have explained to the individual/their representative (tick as appropriate):**

the reasons why a Fast Track application for NHS Continuing Healthcare has been made to the CCG.

that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review

that the purpose of this is to enable the individual’s needs to be urgently met as they have a rapidly deteriorating condition which may be entering a terminal phase.

[ ]

[ ]

[ ]

**Please ensure this form is sent directly to the CCG without delay**

**Name and signature of referring clinician Date**

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**Name and signature confirming approval by CCG Date**

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**Part for completion with the patient**

**About you — equality monitoring**

Please provide us with some information about yourself. This will help us to understand whether people are receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Integrated Care Board. No identifiable information about you will be passed on to any other bodies, members of the public or press.

 1 What is your sex?

Tick one box only

[ ] Male

[ ]  Female

[ ]  In another way

[ ]  I prefer not to answer

 2 Which age group applies to you?

Tick one box only

[ ]  18-24

[ ]  25-34

[ ]  35-44

[ ]  45-54

[ ]  55-64

[ ]  65-74

[ ]  75-84

[ ]  85+

[ ]  I prefer not to answer

 3 Do you have a disability as defined by the Equalities Act 2010?

Tick one box only.

The Equalities Act 2010

Defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

[ ]  No

[ ]  Yes

[ ]  I prefer not to answer

 4 What is your ethnic group?

Tick one box only.

**A White**

[ ]  English / Welsh / Scottish / Northern Irish / British

[ ]  Irish

[ ]  Gypsy or Irish Traveller

[ ]  Any other White background, write below

*Click here to enter text.*

**B Mixed / Multiple ethnic groups**

[ ]  White and Black Caribbean

[ ]  White and Black African

[ ]  White and Asian

[ ]  Any other Mixed / Multiple ethnic background, write below

Click or tap here to enter text.

**C Asian / Asian British**

[ ]  Indian

[ ]  Pakistani

[ ]  Bangladeshi

[ ]  Chinese

[ ]  Any other Asian background, write below

*Click here to enter text.*

**D Black, or Black British**

[ ]  African

[ ]  Caribbean

[ ]  Any other Black / African / Caribbean background, write below

*Click here to enter text.*

**E Other ethnic group**

[ ]  Arab

[ ]  Any other ethnic group, write below

*Click here to enter text.*

**Prefer not to say**

[ ]  I prefer not to answer

 5 What is your religion or belief?

Tick one box only.

Christian includes Church of England/Wales/

Scotland, Catholic, Protestant and

all other Christian denominations.

[ ]  None

[ ]  Christian

[ ]  Buddhist

[ ]  Hindu

[ ]  Jewish

[ ]  Muslim

[ ]  Sikh

[ ]  Prefer not to answer

Any other religion, write below

*Click here to enter text.*

 6 Which of the following best describes your

sexual orientation?

Tick one box only.

[ ]  Heterosexual or Straight

[ ]  Gay or Lesbian

[ ]  Bisexual

[ ]  Prefer not to answer

Other, write below

**Reminder of Guidance Notes**

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 and licb.ft@nhs.net

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