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

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| **1.1 Referral** | **YES** | **NO** |
| **Referral for palliative services? (see 1.1.2)** | [ ]  | [ ]  |
| **Referral for fast-track funding?**  | [ ]  | [ ]  |
| **Does the individual display daily changes?** | [ ]  | [ ]  |

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| **1.1.2 Confirm (√) which service(s) you would like your referral to be forwarded to** |
| LCHS Community Nursing | [ ]  |
| LCHS Macmillan  | [ ]  |
| St Barnabas Hospice | [ ]  |
| Local Neighbourhood Team  | [ ]  |

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| **1.1.3 Consent and Knowledge** |
|  | **Diagnosis** | **Prognosis** | **Referral\*** |
| **Is the patient\* aware of?** | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  |
| **Is the preferred contact aware of?** | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  | **YES** [ ]  **NO** [ ]  |
| **Is there LPOA for Health & Welfare? (this must be seen)** | **YES** [ ]  **NO** [ ]  | **Consent for sharing of information?** | **YES** [ ]  **NO** [ ]  |
| **Are there any interpreter requirements? (e.g. preferred language, to include sign language)** |  |

**\*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** | {nhsnumber} | **Current Location** |  |
| **Home Address** |  | **Discharge Address (if different from home)** |  |
| **Home Contact No** |  | **Discharge Address Contact No** |  |
| **GP Name** |  | **GP Address** |  |
| **Preferred contact details****(Mandatory)** | **Name:****Address:****Email address (if known):** | **Preferred Contact Tel No****(Mandatory)** |  |
| **Date of discharge (please ensure you inform LCHS/CHC should the individual die/become not medically optimised** |  |  |  |

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| **1.3 Clinical Details**  |
| **Confirmed diagnosis of life limiting illness** |  |
| **If cancer, any metastasis?** |  |
| **Phase of illness (**[**click here**](https://www.hyms.ac.uk/assets/docs/research/outcome-measures-in-palliative-care.pdf)**, p.8)** |  |
| **Karnofsky index (**[**click here**](https://www.hyms.ac.uk/assets/docs/research/outcome-measures-in-palliative-care.pdf)**, p.10)** (choose the appropriate percentage according to the scale provided) | Choose an item. |
| **Prognosis** |  |
| **Does the patient have a ReSPECT Form?** | **YES**[ ]  | **NO**[ ]  |
| **What is the patient’s resuscitation status at time of referral?** | **YES**  [ ]  (For resuscitation)  | **NO** [ ]  (Not for resuscitation) |

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| **1.4 Further details** | **YES** | **NO** | **Comments** |
| Are there any other health conditions? | [ ]  | [ ]  |  |
| Are there any known infections? (to include Covid 19) | [ ]  | [ ]  |  |
| Has the patient got a signed ADRT? | [ ]  | [ ]  |  |
| Has an advance care plan been completed? | [ ]  | [ ]  |  |
| Does the patient have complex needs, psychological or symptomatic? | [ ]  | [ ]  |  |
| Does the patient live alone? | [ ]  | [ ]  |  |
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| **1.4.2 Attach** Care & Support Plan/Advance Care Plan or answer the questions below: |
| **What do I want to achieve?** (Health and care outcomes and goals to be delivered) |  |
| **How will I achieve my outcomes and goals?** (Including where other organisations will be supporting) |  |

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| **PART 2 - Handover of patient**  |

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| **2.0 Care Requested** | **Patient Details must be given for ALL areas (Please remember this is your handover of your patient to the ongoing care provider)** |
| All aspects of personal care |  |
| Breathing |  |
| Nutrition |  |
| Continence |  |
| Skin |  |
| Mobility(Please include if hoist is required) |  |
| Communication |  |
| Psychological & Emotional |  |
| Cognition |  |
| Behaviour |  |
| Drug Therapies & Medication |  |
| Altered States of Consciousness |  |

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| **2.1 Current nursing home or care agency details This section is only required if requesting fast track funding** |
| **Private Carers in place?** [ ]  **Agency care package already in place?** [ ] **If so, which Agency (please advise if this is funded by Social Care)?** Please give number of hours provided in current package:**Nursing Home Placement required YES**  [ ]  **NO**  [ ] **Any preference of care home (Should be an ICB approved home):** (Please remember we cannot guarantee any preference of care home) |

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| **2.2** **Care Agency Package** | **This section is only required if requesting fast track funding**(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 |   |   |   |   |   |   |   |
| Total Hours |  |  |  |  |  |  |  |

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| **2.3 Environmental assessment:** | **YES** | **NO** | **Details must be given for ALL applicable fields** |
| 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 Lifeline available? |[ ] [ ]   |
| What facilities are available to carers? (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.*Please continue a separate sheet where needed. This should include the patient’s name and NHS number, and this should 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 ICB.

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 ICB without delay**

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| **Referrer Details***This* ***must be*** *a registered nurse or doctor if applying for fast track (Care home nurses are* ***unable*** *to complete this document due to conflict of interest)* |
| Signature  |
| Name: |  |
| Job Title: |  |
| Date: |  |
| Telephone Number: | Mobile: Land Line: |

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| **ICB Approver Details** *Confirming approval by the below* |
| Signature  |
| Name |  |
| Job Title |  |
| Date |  |

**Important Guidance Notes**

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

**The whole document MUST be completed if referring for a Fast Track**

**If referring for services, then box 2.1 (Care Agency Package) is not required to be completed.**

**For CHC Fast Track funding application please send to:** licb.ft@nhs.net

**For Planned Palliative Referrals please send to:** lhnt.lchsreferrals@nhs.net

Patient Equality Monitoring

We collect equalities information to meet our duties under the Equality Act 2010 and develop our insights into CHC patients and ensure we provide appropriate care. The categories included in the questions may not be exhaustive or reflect how you feel or identify. We will be reviewing these to align with approaches across Government. Filling these in is optional, and you do not have to provide an answer if you do not wish to do so.

Please provide us with some information about yourself. We collect information to help us understand whether people are receiving fair and equal access to NHS Continuing Healthcare (CHC) via the [NHS CHC Patient Level Data Set (PLDS)](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdigital.nhs.uk%2Fdata-and-information%2Fdata-collections-and-data-sets%2Fdata-sets%2Fcontinuing-health-care-data-set%2Fcontinuing-health-care-patient-level-data-set&data=05|01|Alexandra.Ostendorf%40dhsc.gov.uk|119fe136c12d434e338b08da27880ce0|61278c3091a84c318c1fef4de8973a1c|1|0|637865762542945475|Unknown|TWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D|3000|||&sdata=%2FwQZjI%2BazdZre6g3bOdZOowvicbzpVuGJxq625%2BT1jI%3D&reserved=0) which is used to help achieve better patient outcomes, better experiences and better use of resources in CHC. The lawful basis for collecting this information is Article 6 (1) (c) of the GDPR enacted by the Data Protection Act 2018. Please note that NHS CHC PLDS data is pseudonymised for analysis purposes. This means that identifiers such as names, NHS numbers and dates of birth are removed. Detailed information about the use of individual’s identifiable data is publicly available at [https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/gdpr/gdpr-register](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdigital.nhs.uk%2Fabout-nhs-digital%2Four-work%2Fkeeping-patient-data-safe%2Fgdpr%2Fgdpr-register&data=05|01|Alexandra.Ostendorf%40dhsc.gov.uk|119fe136c12d434e338b08da27880ce0|61278c3091a84c318c1fef4de8973a1c|1|0|637865762542945475|Unknown|TWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D|3000|||&sdata=hxf4ApAyRdEyAK0qaBm83DjjrOhGA1KqtvjzAJarhUI%3D&reserved=0)

 **1 What is your gender? Tick one box only**

☐ Male

☐ Female

☐ Indeterminate (unable to be classified as either male or female)

☐ 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 Equality 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

☐ British

☐ Irish

☐ Any other White background (write below) (click here to enter text)

##### B Mixed

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any other Mixed background (write below)

(Click here to enter text)

##### C Asian or Asian British

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Any other Asian background (write below)

(Click here to enter text)

##### D Black, or Black British

☐ African

☐ Caribbean

☐ Any other Black background (write below)

 (Click here to enter text)

##### E Other ethnic group

☐ Chinese

☐ Any other ethnic group, write below

Click here to enter text.

☐ I prefer not to answer

#### 5 What is your religious or belief system affiliation? Tick one box only

☐ Baha'i

☐ Buddhist

☐ Christian

☐ Hindu

☐ Jewish

☐ Muslim

☐ Pagan

☐ Sikh

**5 Continued/**

☐ Zoroastrian

☐ Other

☐ None

☐ Prefer not to answer

☐ Unknown

#### 6 Which of the following best describes your sexual orientation? Tick one box only

☐ Heterosexual or Straight

☐ Gay or Lesbian

☐ Bisexual

☐ Other sexual orientation

☐ Prefer not to answer

☐ Other (write below)

 (Click here to enter text)

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