NHS
Gloucestershire Hospitals
NHS Foundation Trust

Community Specialist Palliative Care Nursing Service Referral Form

Name:	
Date of Birth:	DD / MM / YYYY
MRN Number:	
NHS Number:	
(OR AFFIX HOSPITAL LABEL HERE)	

Please email all referrals to: ghn-tr.communitypalcare@nhs.net **Specialist Palliative Care Services are available for patients with life threatening illnesses that are experiencing complex problems, and have not responded to current management.**	Gloucestershire Community Palliative Care Nursing Team Gloucestershire Royal Hospital Beacon House Great Western Road Gloucester GL1 3NN Telephone No: 0300 422 5370

Patient details	
Address:	Marital status:
	Ethnic group:
Postcode:	Religion:
Telephone no:	Next of kin / carer
Age:	Relationship:
Male ❑ Female ❑	Contact no:
Patient aware or referral **Yes** ❑ **No** ❑	Carer aware of referral **Yes** ❑ **No** ❑
Relevant family issues:	Address (if different from patient's address):

GP	1. Consultant
Telephone no	2. Consultant
Address	Location of patient (at time of referral)

Medication list - Please fax GP summary or recent discharge summary (if no changes to medication leave blank)	
Allergies and sensitivities	Type of reaction
Drug/dose/frequency	Drug/dose/frequency
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient name	D.O.B
MRN Number	NHS Number

Reason for referral

What are the key concerns that require specialist palliative care input? (Bullet point, list or free text fine)

Pain control	❑	Therapy support	❑
Other symptom control	❑	Care in the last days of life	❑
Emotional/psychological/spiritual support	❑	Carer needs	❑
Social/financial support	❑	Advance care planning	❑

Response required (in your opinion) ❑ **Two working days (RED)** (Please phone to discuss) ❑ **One week (AMBER)** ❑ **Two weeks (GREEN)**

Condition of patient

Current treatment intent? (Please tick)

Symptom control ❑ Life prolonging ❑

Phase of illness? (Please tick)

Stable ❑ Unstable ❑

Deteriorating ❑ Dying ❑

Expected prognosis? (Please tick)

Days ❑ Weeks ❑

Months ❑ Years ❑

Performance status?
Please circle the number that best describes the patients condition

1	Ambulatory and able to carry out light work.
2	Ambulatory, capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours.
3	Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours.
4	Cannot carry out any self-care. Totally confined to bed or chair.

Currently in place?	Yes	No	N/A	Details
Anticipatory Medication	❑	❑	❑	
DNACPR	❑	❑	❑	
Any advance directive/decision	❑	❑	❑	
Preferred place of care	❑	❑	❑	
On EPaCCS (end of life register)	❑	❑	❑	

Medical information

Diagnosis and date
Site of any metastases and date (if applicable)
Comorbidities

Referrer details

Print name	Telephone no
Job title and place of work	Date of referral