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**Broad Lane, Rochdale, OL16 4PZ**

**Tel. 01706 649920. Fax. 01706 644943**

**Email.** [nehgm.liaison@nhs.net](mailto:nehgm.liaison@nhs.net)

**HOSPICE IN PATIENT UNIT (IPU) REFERRAL FORM**

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| --- | --- | --- |
| **Reason for Hospice IPU Referral** Please tick either symptom control **OR** end of life care & complete the form in full with all requested information for each section. Incomplete forms will be returned. Please also attach any relevant clinical information/ letters/contact assessments | **Symptom Control □** | **End of Life Care (patient is in last days of life) □** |
| |  |  | | --- | --- | | **Is the patient aware that this referral has been made? Yes □ No □**  **Is the patient’s GP aware that this referral has been made? Yes □ No □**  **\*\*Please note this referral will only be processed if the patient and/or family are aware and have given consent\*\*** |  | | | |

**Patient details:**

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First name: | Sex: |
| Address: | Ethnicity: |
| Language: |
| Postcode: | Interpreter required? |
| Tel. No. | Marital status: |

**Patient information:**

|  |  |
| --- | --- |
| Diagnosis: | Location of patient:  Home □ Hospital □ (please specify Hospital & ward) |
| Date of Diagnosis |
| NHS Number: | Does the patient live alone? Yes □ No □ |

**Next of Kin/Carer details:**

|  |  |
| --- | --- |
| Surname | Address: |
| First name: |
| Relationship to patient | Postcode: |
| Tel. Number: |

**GP Details & Other services involved:**

|  |  |
| --- | --- |
| GP name:  Address:  Tel. Number: | Specialist Nurse name:  Tel. Number: |
| District Nurse Name:  Tel Number |
| Other (please specify) |

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| **Reason for referral:** ***(Please indicate current problems and the specific aims of this referral)*** |

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| **Other relevant medical history: *(include information regarding past medical history, other current illnesses, treatments, outcomes, prognosis).*** |

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| **Nursing/Physical:** ***(include details of the patient’s ability to complete Activities of Daily Living, bowel issues, appetite problems, mobility issues, any current dressings / wounds, IV therapies, the day-to-day nursing needs of patient, are they bariatric, on O2, any aerosol generating procedures etc.)*** |

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| **Social situation:** ***(Any current care package details, what is the current housing situation, whether living with family, any financial issues, any existing community support, issues with access to property, are there any foreseeable risks?)*** |

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| **Emotional/psychological/spiritual/insight:** ***(include information regarding the patients’ knowledge of their illness, their prognosis, feelings and fears, importance of religion, communication barriers (for both patient & carers), ability to make decisions).*** |

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| **Present medication: *(drugs, doses, frequency (or send current list).*** |

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| --- | --- |
| **Further information:**  GSF register? Yes □ No □  Advance Care Plan? Yes □ No □  Key-safe in place? Yes □ No □  Preferred place of care? Yes □ No □  (if yes, please state where ………………………….) | SR1 form issued? Yes □No **□**  Continuing Healthcare Funding? Yes □ No □  Anticipatory drugs prescribed? Yes □ No □  uDNACPR form? Yes □ No □ |

**Referrer details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Address: | | Tel. Number: | |
| GP □ | Consultant □ | Specialist Nurse □ | | District Nurse □ | | Other □ (specify) |

|  |  |
| --- | --- |
| Print Name:  Signature: | Date: |