Please complete all details to ensure your referral is not delayed
Fax: 720292 If faxing ensure both sides are faxed

Jersey Hospice Care
your care, your choice, your time

EXTERNAL REFERRAL FORM

Patient details			
Surname:			**Tel no:**
Forenames:		**Title:**	**Does the patient consent to the referral?** **Yes** ☐ **No** ☐ **If no, give reason:**
URN:		**DOB:**	
Address: ADDRESSOGRAPH			**COVID 19 status**
			Date of swab
			Other known infections
Allergies			
Current location of patient: Home ☐ Nursing Home ☐ Residential Home ☐ Hospital ☐ **Ward name**:			
GSF code	**Blue (A)** ☐ Year plus prognosis	**Green (B)** ☐ Months prognosis	**Amber (C)** ☐ Weeks prognosis	**Red (D)** ☐ Days prognosis

GP and referrer's details	
GP name	Referrer's name
GP surgery	Referrer's role
GP tel no	Referrer's tel no
If patient in the community is GP agreeable to referral? Yes ☐ No ☐	If patient is in hospital is the Consultant/Registrar agreeable to referral ? Yes ☐ No ☐

First contact details	
Name:	**Relationship to patient:**
Patient agrees to named person being contacted: **Yes** ☐ **No** ☐	**Tel no:**

Patient's condition
Diagnosis and co morbidities:
Reason for referral and key concerns requiring specialist palliative care input: Insufficient information may result in a delayed response while further detail is sought.
History of recent events

Patient's Name: _____ **DOB:** _____ **URN:** _____

Australian Karnofsky Performance Status		
100%	Normal, no complaints, no evidence of disease	☐
90%	Able to carry on normal activity, minor signs or symptoms of disease	☐
80%	Normal activity with effort, some signs or symptoms of disease	☐
70%	Cares for self, but unable to carry out normal activity	☐
60%	Able to care for most needs, but requires occasional assistance	☐
50%	Considerable assistance and frequent medical care required	☐
40%	In bed more than 50% of the time	☐
30%	Almost completely bedfast	☐
20%	Totally bedfast and requiring extensive nursing care by professionals and/or family	☐
10%	Comatose or barely rousable, unable to care for self, requires equivalent of hospital care, disease may be progressing rapidly	☐

Special Considerations

Please indicate any special considerations eg cultural, ethnic, spiritual, gender, relationships, diet, body image, information sharing

Risk Assessments

Please indicate if there are any potential risks or concerns that may affect patient, family or staff safety eg infections, drug or alcohol misuse, lone worker

Resuscitation status

Has a discussion regards DNACPR been undertaken?	Is DNACPR form in place?
Yes ☐ No ☐	Yes ☐ No ☐

Communication

Language(s):	Is interpreter needed?	Yes ☐ No ☐

Infections

Please list any known infections.

Hospice clinical services being requested

Medical Team	Ward based assessment	☐	Out-patient appointment Community Visit	☐ ☐
Clinical Nurse Specialist	Ward based assessment Community / home visit	☐ ☐	Out-patient appointment in nurse led clinic	☐
IPU	IPU admission	☐	**If urgent contact IPU directly**	
King Centre Day Services	Day Hospice Physiotherapist Complementary Therapist	☐ ☐ ☐	Lymphodema Practitioner In Control Group Counsellor	☐ ☐ ☐

For Hospice use only (must be completed on triage)

Contact patient : within 48 hours ☐ **within 2 weeks** ☐ **within 3 weeks** ☐

Name of Jersey Hospice service(s) to be accessed :

Other actions: e.g. contact referrer for more information

Doctor signature:	**Date:**	**Time:**