

Patients with physical symptoms, psychological distress, or requiring care in the last few days of life may benefit from Willow Wood Hospice.

ESPECIALLY:

- Patients living with cancer (and their families).
- Patients who have limited life expectancy (e.g. end-stage neurological disease, HIV/AIDS).

WHAT CAN WILLOW WOOD HOSPICE OFFER?

- The Willow Wood Hospice Multidisciplinary Team is trained in palliative care.
- The Out-Patient Clinic, Day Hospice and In-Patient Unit can be used to assess care needs, when appropriate.
- Neither the In-Patient Unit nor Day Hospice can offer long term care - patients and their families need to be aware of this prior to referral.

HOW CAN YOU REFER PATIENTS TO WILLOW WOOD HOSPICE?

- Please complete the attached Referral Form.
- A multidisciplinary referrals review meeting is held every weekday morning at 9.30am. All referrals are discussed at this meeting. Please do not hesitate to contact the Matron, Medical Director, Medical Secretaries or the In-Patient Unit (weekends) directly for further advice regarding referrals.
- The patient **must** consent to referral to the Hospice.
- Patient care needs may be assessed through the Out-Patient Clinic, Day Hospice or In-Patient Unit

Please note:

As from January 1st 2009 Willow Wood Hospice will become a non-smoking site. We would ask that patients, relatives and carers are made aware prior to referral.

Smoking cessation programmes/aids will be made available to patients.

Further copies of this form are available on our website: www.willowwood.info

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE AND DETAILS OF CURRENT DRUGS WITH THIS FORM

Tel: 0161 330 1100

Fax: 0161 330 1144

Patient Details			Office Use Only		
Surname	Male / Female	Patient consent to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospice No		
First Name			Date rec'd		
Address		GP aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Action		
	Postcode		IPU	DH	OPC
Ethnicity	Phone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marital Status	Mobile		Signature		
NHS No	DoB	Age			

Primary diagnosis(es)
Any other metastatic sites/complications?
Is the disease industrially related?

Communication		
First language if not English	Communication in English (circle)	Good / Fair / Poor
Would interpreter be helpful to patient and Hospice staff? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other barriers to communication (e.g. hearing loss, confusion)		

Next of Kin/Representative	Social Services Yes <input type="checkbox"/> No <input type="checkbox"/>	General Practitioner
Name	Name	Name
Address	Based at	Address
	Telephone	
	Fax	
Telephone	Continuing care assessment completed	Telephone
Relationship	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fax/email
Main carer	District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	Macmillan Nurse
Name	Name	Name
Telephone	Based at	Address
	Telephone	
	Fax	

Reason for Referral	Services Required	The patient is currently
<input type="checkbox"/> Terminal care <input type="checkbox"/> Symptom control (e.g. pain, breathlessness – please state)	<input type="checkbox"/> Out-Patient Clinic Assessment <input type="checkbox"/> Day Hospice <input type="checkbox"/> In-Patient unit <input type="checkbox"/> Deferred	<input type="checkbox"/> At home <input type="checkbox"/> In hospital (see over) <input type="checkbox"/> Elsewhere (e.g. Nursing Home) Does patient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete as fully as possible, it will assist the Hospice in making decisions regarding priority for assessment

Patient Name

In-Patient Details (if currently in Hospital)			
Hospital	Telephone	Ext	
Ward	Is Macmillan team involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consultant (1)	Consultant (2)		
MRSA Status	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not known
CPR Status	<input type="checkbox"/> Yes	<input type="checkbox"/> Not known	<input type="checkbox"/> DNR

Brief History of diagnosis(es) and Key treatments (to be completed by all referees)		
Date	Progression of disease and investigations/treatment	Consultant and hospital

Treatments Received		
Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No
		Radiotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No

Current problems	
1.	3.
2.	4.
Mobility: <input type="checkbox"/> Mobile <input type="checkbox"/> Mobile with assistance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed-bound	

Referrer's expectation of current treatment (circle)	Symptom control / Terminal care
Estimated prognosis (circle)	Days / Weeks / Months / Years

Past Medical/Psychiatric History	Current Medication/Allergies

Insight	
Has patient been told diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the carer aware of patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient discuss the illness freely? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Has patient/carers been informed of no smoking policy	<input type="checkbox"/> Yes
Has patient/carers been informed that smoking cessation aid/programme are available	<input type="checkbox"/> Yes

Any other comments/information

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature	Name (please print)
Job title	Contact number Bleep no
Surgery or hospital	Date

Please complete as fully as possible, it will assist the Hospice in making decisions regarding priority for assessment