# SPECIALIST PALLIATIVE CARE REFERRAL FORM – Macmillan Unit

ELIGIBILITY CRITERIA FOR ADULTS

Specialist palliative care services are for patients with complex problems.

Complex problems are defined as those which are severe and intractable and have persisted after competent palliative care by generalists.

Complex problems can arise from multiple domains of need:

* physical symptoms, psychological symptoms or spiritual /emotional distress

Patients who have social needs or whose families show exceptional emotional distress may be referred provided that they also have complex problems in one of the above domains.

Prior to referral competent patients must consent. Referral must be judged to be in the best interests of incompetent patients who are referred.

*As agreed by the Dorset Cancer Network in accordance with the National Institute for Clinical Excellence guidance on Improving Supportive and Palliative Care for Adults with Cancer*

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| --- | --- | --- | --- | --- | --- |
| 1. PATIENT | | Fax To: 01202 705213 (community patients)  01202 704162 (in-patients)  Tel: 01202 705470 | | | |
| Patients Name | Patients Address with Post Code | | | | Telephone Number: |
|  |  | | | |
| NHS Number: |
| Hospital No: |
| Date of Birth: | Current Location of Patient: | | | | Patient aware of referral:  Yes No |
| 2. PATIENTS GP AND SURGERY TELEPHONE NUMBER:  GP aware of referral Yes No | | | | | |
| 3. MAIN CARER | | | | | |
| Name | Relationship to Patient | | | | Contact Number |
| 4. REFERRED BY | CONTACT NUMBER | | | | Signature and date |
| 5. CURRENT HOSPITAL CONSULTANT(S) | | | | | |
| • OTHER PROFESSIONALS INVOLVED | | | | (name and phone number where possible) | |
| • District Nurses | | |  |  | |
| • Social Services | | |  |  | |
| • Key worker | | |  |  | |
| • Other | | |  |  | |

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| Patient Name | Date of birth | | |
| 6. DIAGNOSIS AND HISTORY OF THIS ILLNESS | | | |
| • Diagnosis | | | Patient Aware Yes No |
| • History | | | |
| • Treatment to date (e.g. surgery, chemotherapy, radiotherapy) | | | |
| • Reasons for referral (see eligibility criteria overleaf) | | | |
| 7. WHAT SERVICES WOULD YOU LIKE | | | |
| Hospital inpatient assessment | | Outpatients appointment | |
| Home visit by Doctor/Specialist Nurse | | Admission to specialist unit | |
| Day care | | Advice by telephone | |
|  | | Respite – (Joseph Weld only) | |
| 8. ESSENTIAL INFORMATION | | | |
| • Current Medication | | | |
| • Allergies | | | |
| • Relevant medical history | | | |
| • Has patient got a living will/advance statement Yes No Not Known | | | |

Form ref. DCN 01.05