NHS
Sandwell and West Birmingham
NHS Trust

Connected Palliative Care Referral Form

For patients over the age of 18 registered with a Sandwell and West Birmingham GP with a diagnosis of a life limiting illness AND less than 12 months prognosis OR Specialist Palliative Care needs.

PATIENT DETAILS

NHS Number		**Forename**		**Surname**	
Date of Birth		**Language**		**Interpreter**	Yes ◯ No ◯
Gender		**Ethnicity**		**Religion**	

Address

Post code

Current Location (please specify hospital & ward)

☐ Home ☐ Nursing Home
☐ Care Home ☐ Hospice
☐ Hospital ☐ Other

(Specify hospital & ward) _____

Contact No.				
Mobile No.				

Prognosis (Please ref to SPICT/GSF)

Years	Months	Weeks	Days
☐	☐	☐	☐

Consider prescribing **anticipatory** meds

REFERRER

Job Title		**Forename**		**Surname**	
Email Address		**Contact No.**		**Date last seen**	

REASON FOR REFERRAL

Diagnosis

Urgency of Referral

2 Day		5 Day		10 Day	
	☐		☐		☐

Current needs

☐ Symptom Control ☐ Emotional, Psychological or Spiritual Needs ☐ End of Life Register ONLY
☐ Hospice Admission ☐ Therapy Services ☐ Living Well Services ☐ Carer Support / Respite
☐ Other Reason _____

How can we help? (Please include main diagnosis, brief PMH, and current treatment plan. If symptom management required, please indicate the symptoms and medication/doses that have been tried)

Attach any appropriate clinical annotations with the referral to us and include any useful information such as discharge summary / current medication list / housing issues / allergies / drug or alcohol dependency etc

TEP/ReSPECT Forms in Use	Yes ☐ No ☐	**DNACPR in place**	Yes ☐ No ☐	**Anticipatory Meds in Place**	Yes ☐ No ☐	**MASC form in place**	Yes ☐ No ☐
Hospital Admission considered	Yes ☐ No ☐	**Preferred Place of Care**		**Preferred Place of Death**			

GP

GP Name / Surgery Address		**Contact No.**	

NOK

Name (Primary)		**Relationship**		**Contact No.**	
Name		**Relationship**		**Contact No.**	

CONSENT

Has consent been gained for Palliative Care Team to be involved and to be added to EOL Register				Has consent been gained for information being shared Y/N (If No, please supply a reason)			
Patient	☐	**NOK**	☐	**Patient**	☐	**NOK**	☐

Please use this space to provide us more information about your referral such as current medication list / housing issues / allergies, this will help us process the referral and ensure the most appropriate person makes contact as soon as possible.

Any useful information such as annotations/discharge summaries will also be helpful.

If the form is being completed by a GP practice that uses system one, please confirm you have shared your records. ☐