



Referral to Leeds Hospices from Emergency Department - Triage Form							
Preferred Hospice –			Date		Time		
Patient name –			NHS No			DOB	
Next of Kin name			Relationship to patient			NOK Contact No	
Next of kin aware of transfer ? Indicate Y/N		If No (give details)					
GP Practice Postcode			Main diagnosis				
Hospital		Ward	Reason for ED attendance:				
Reason for referral: EOLC			Referrer's name and contact number:				
The patient meets following admission criteria:		<input type="checkbox"/> Prognosis measured in hours/short days <input type="checkbox"/> No reversible causes for deterioration/not appropriate to treat these <input type="checkbox"/> Decision to transfer agreed by responsible Consultant <input type="checkbox"/> Patient (where able) and family understand prognosis and wish for Hospice transfer OR <input type="checkbox"/> Decision to transfer is a Best Interests decision as patient lacks capacity to be involved in decision making				Each criteria should be ticked	
Additional Information:							
Airway Issues:			Indicate Y/N				
Tracheotomy in situ?							
Suctioning required?							
Oxygen required? Document flow rate							
Patient Safety							
Is a side room required?							
Source isolated ?							
Transport – Book ALL Transport with 1 Escort							
DNA/ CPR		Stretcher		Complex needs requiring nurse escort		Syringe driver	
Hospice staff member receiving information: Name: Position:							

Hospice audit			
Patient Transferred?			
Yes		No	
If Y time patient arrived in hospice		If No what prevented transfer?	
		Inappropriate referral	
		No bed available	
		Lack of nursing staff	
		Lack of medical staff	
		Other	
Outcome			
Date of Death		Location of Death	
Comments			
If there were any issues or problems with the transfer please complete an issue log.			