Leeds Palliative Care Network

Referral to Leeds Hospices - please see PPM for full details					
Preferred Hospice – delete as needed			SGH / WFH		
Patient name:			**NHS No:**	**DOB:**	
GP Practice:			**See PCT assessment date:**		
Hospital:	**Ward:**		**Main diagnosis:**		
Reason for referral:				**Referrer's name:**	
Symptom management	Y/N	EoLC	Y/N	Emotional support patient or family	Y/N
Safeguarding		Y/N	Other		
Additional Information – add below Please highlight any safeguarding concerns or issues.					

Airway Issues:	
Tracheostomy	Y/N
Suctioning	Y/N
Mental Capacity/Dementia/Cognitive Impairment	
Is the hospice referral a best interest's decision?	Y/N
Does the patient have 1:1 carer/nurse?	Y/N
Behavioural challenge?	Y/N
DoLS in place?	Y/N
Patient Safety	
At risk of Covid19 exposure?	Y/N
Is a side room required?	Y/N
Source isolated?	Y/N
IV Antibiotics	Y/N
Risk of falls? - nursed in an enhanced bay	Y/N
Is patient's skin integrity compromised/existing pressure ulcer?	Y/N
Complex dressings	Y/N
Continuous sub/cut infusion (CSCI)	Y/N
Medication (drug and dose) in CSCI:	

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Oxygen/Nebuliser Requirements							
O2 required		Y/N		What is the flow rate?			
Nebuliser required?		Y/N					
Enteral/Parental Feeding							
TPN	Y/N	Enteral Feeding tube		Y/N	IV fluids	Y/N	
Transport – Book ALL Transport with 1 Escort							
DNACPR	Y/N	Stretcher	Y/N	Complex needs requiring nurse escort	Y/N	Bariatric patient	Y/N

Please email this form to neyh.leeds.hospices@nhs.net