The Rosemary Foundation Referral Form

24/7 on-call clinical team: 01730 269996 care.peterfield.therosemaryfoundatiovn7v3@nhs.net

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| Patient  Name:  Address:  Phone: | |  | | | Urgency of referral:  URGENT within 24-48hrs due to:  Care in dying  Urgent ongoing symptom management  Support network fragile  Safeguarding concerns (add to summary)  **URGENT REFERRALS NOT ACCEPTED** without **DNAR and JIC/PRN in place**  Or:  Within 5 days For:  Background support  Within 10 days  Symptom management  Within 4 weeks for  Temp bridging for help with ADLs  Introduction to service  Fragile support network  Volunteer visitor  Counselling service  Safeguarding (add to summary)     * Patient consented to referral   and **aware TRF is an EOL service**:  Yes  No   * Patient consented to sharing   of information:  Yes  No | | | | |
| DOB:  NHS no:  Pronoun: | | He  She  They | | |
| **Karnofsky score:**  Likely prognosis: | | **%**  Hours  Days  Weeks  Months | | |
| NOK:  Relationship:  Address:  Phone: | |  | | |
| Preferred place of care:  Home  Hospice  Other  Preferred place of death:  Home  Hospice  Other | | | | DNACPR / Respect  completed:  JIC medication px: | | | Yes  No; to be completed by:  Yes  No | PRN chart completed:  CSCI chart completed: | Yes  No  Yes  No |
| Diagnosis and stage:  History of illness:  Treatments:  Main symptoms: | | | | | | | Relevant PMH including mental health, sepsis and infection risks:  Allergies:  History of substance abuse:  Yes  No  Details: | | |
| Treatment Escalation plan: | | | | | | | | | |
| Communication ability:  Learning disability:  Dementia:  CHC FT status:  POC details:  Care agency:  HCPs involved:  District nurses  MacMillan  Other SPCT:  Other: | | | Y  N  Y  N  Y  Y  Y | | Lives alone  Yes  No  If yes: Are they vulnerable and why?  Safeguarding concerns:  If no, lives with:  Mobility:  Currently requiring care with:  Who is currently supporting the patient and how?  Safety issues for staff: | | | | |
| Summary of referral: | | | | | | | | | |
| Referrer | Name: | | | | | Role: | | Date of referral: |  |
| Place of work: | | | | | Contact details: | | | | |