**SPECIALIST PALLIATIVE END OF LIFE (PEoLC)**

**CO-ORDINATION CENTRE SBAR REFERRAL FORM**

(**ALL Sections Must Be Completed)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SITUATION** | | | | |
| Referral Date: | | Referred by: | | |
| GP: | | Position: | | |
| Other professionals involved: | | Contact Number: | | |
| **INFORMATION SHARING** | | | | |
| Patient consent to referral | | Yes | | No |
| Consent received to share information with other health professionals | | Yes | | No |
| Consent received to share SystmOne record | | Yes | | No |
| **BACKGROUND** | | | | |
| **PATIENT DETAILS** | | | | |
| **Name** |  | **Preferred Name** |  | |
| **DOB** |  | **NHS NUMBER** | | |
| **Address** |  | | | |
| **Home Tel** |  | **Mobile** |  | |
| **Religion/Spirituality** |  | **Ethnicity** |  | |
| **First Spoken Language** |  | **Interpreter Required?** |  | |
| **NEXT OF KIN DETAILS** | | | | |
| Name |  | Address |  | |
| Relationship |  | Contact Numbers |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASSESSMENT** | | | | |
| **CLINICAL INFORMATION** | | | | |
| Palliative Diagnosis (please include metastases if relevant): | | | Date of Diagnosis: | |
| Other Relevant Conditions: | | | Are there any communication problems: | |
| Is the patient receiving any ongoing active treatment? | | | ReSPECT/EPaCCS in place: | |
| Allergies: | | | Is patient and/or next of kin aware of diagnosis/prognosis? | |
| **RECOMMENDATION** | | | | |
| **REASON FOR REFERRAL**  **(PLEASE PROVIDE US WITH AS MUCH INFORMATION AS POSSIBLE ABOUT THE MAIN ISSUE/PROBLEMS THAT HAVE LED TO THIS REFERRAL** | | | | |
| **□ Physical** |  | | | |
| **□ Psycho-Social** |  | | | |
| **□ Spiritual** |  | | | |
| **□ Pain/Symptom Management**  **Have First Line Medications Been Trialled?** |  | | | |
| **□ Family/Carer Need** |  | | | |
| **□ Other** |  | | | |
| **ADDITIONAL INFORMATION** | | | | |
| Mobility: | | Feeding: | | Communication needs: |
| Palliative Treatment/Active Treatment: | | Risks at Home to Identify: | |  |
| **REFERRAL CRITERIA** | | | | |
| * Adults (18yrs +) * Patients registered with a North Lincolnshire GP or any resident of North Lincolnshire that is unregistered. * Life-limiting / terminal condition in advanced or progressive stages * Requiring support with any of the below: * Physical symptoms that are difficult to manage * Emotional support needs that cannot be met by usual treating team * Circumstances where there are difficulties with care needs/family support and/or frequent hospital admission as a result of a specific symptom * End of life goals including memory work, advanced care planning, access to social group/activities   Referrals will be considered for those with a recent diagnosis for which radical treatment is being offered but who have overwhelming symptoms (physical and emotional) that cannot be managed by treating team  Referrals will be triaged and the referral will be seen by the most appropriate team members to meet the individuals needs | | | | |
| * For further information, or if you would like to discuss a referral, please contact the **Butterfly Line** on: **01724 454392** | | | | |
| **Office use only:** | | | | |
| **Date received:** | | **Triage completed by:** | | **Priority and plan:** |