Community NHS Supportive Care at Home Referral Form

(September 2024)

Please note the sections marked with a * are mandatory fields and must be fully completed or the referral will be rejected.

South West Yorkshire Partnership NHS Foundation Trust

Date of referral: ……………………………………..

PATIENT DETAILS

*Name:

*Address:

*DOB:

*Post code:

*NHS number:

*Telephone number:

*Registered GP and practice:
(patient must be registered to a Barnsley GP practice)

*REFERRED BY

Name:

Designation:

Telephone Number:

Email Address:

SERVICE INCLUSION CRITERIA

The service is provided to individuals who are approaching or are in the last days of their life and require overnight support to die in their preferred place of care. ***This is for 1 – 2 nights per week*** dependant on service capacity and assessment of patient.

To ensure the individual being referred meets the service's inclusion criteria please ensure that the following points are confirmed:

*The individual being referred must have CHC fast track funding agreed and is already receiving care and support from other services, for example, district nursing service. ☐

*Has patient consented to discussion with service: Yes ☐

*REASON FOR REFERRAL *Please tick the primary reason(s) for referral:-*

Family / Carers Respite ☐

Last Days of Life Care ☐

Pain / Symptom Management by Qualified Nurse ☐

Patient Support ☐

SIGNIFICANT OTHERS / FAMILY – Please provide at least one contact

1st Contact

Name:

Relationship:

Address:

Telephone Number / Mobile:

Is the person the next of kin: Yes ☐ No ☐

2nd Contact

Name:

Relationship:

Address:

Telephone Number / Mobile:

Is the person the next of kin: Yes ☐ No ☐

E-mail completed referrals to: rightcarebarnsleyintegratedspa@swyt.nhs.uk

DIAGNOSIS AND SUMMARY OF MAIN CONCERNS
Current problems (please give a brief summary of patient's / carers perception of needs):

ADDITIONAL PATIENT DETAILS

Is Patient on O2: Does Patient Live Alone:

Current location of patient: Is patient supported by My Care Plan:

ReSPECT form or DNACPR in place: Yes ☐ No ☐

FURTHER INFORMATION

Can the patient mobilise on their own, if no is there a current moving and handling assessment

Continence status: Any known pressure areas:

Is there any equipment in place: Is patient taking any diet / fluids:

Is there a syringe driver in situ: Is pre-emptive medication in place:

RISKS

Are there any identified risks or safeguarding concerns?

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