N.B. All sections to be completed in full or referral will not be triaged. Please provide as much detail as possible.

Email completed forms to [nightingalehousereferrals@wales.nhs.uk](mailto:nightingalehousereferrals@wales.nhs.uk)

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| **REFERRER CONTACT DETAILS** | | | | | | | |
| **Referral Date** |  | **Contact Name** |  | | | **Team / Location** |  |
| **Contact Number** |  | | | **Email address** |  | | |

***Urgent referrals / advice*** please contact **01978 316806** (Mon-Fri 8:30am-4:30pm) or **01978 316800** (out of hours).

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| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| **Patient Name** |  | | | | **NHS No** | | |  | | | | **Date of Birth** | |  | | | | | **Age** |  |
| **Home Address**  inc. Postcode |  | | | | | | | | | | | | | | | | | | | |
| **Phone – Home** |  | | | | **Phone - Mobile** | | |  | | | | **Ethnicity & Preferred Language** | | | | |  | | | |
| **Main Carer /**  **Next of Kin** |  | | | | **Relationship** | | |  | | | | **Main Carer Contact No** | | | | |  | | | |
| **GP Name & Surgery Details** |  | | | | | | | | | | | | | | | | | | | |
| **Patient / Family expectations of referral** |  | | | | | | | | | | | | | | | | | | | |
| **Patient’s current location** | Home  WMH  CoCH  Other Hospital  Hospice  Care Home  Other: Enter other location Hospital & Ward / Care Home: | | | | | | | | | | | | | | | | | | | |
| **Awareness – Diagnosis** | | Patient | | Family | | | | **Awareness – Prognosis** | | | | | Patient | | | | | | Family | |
| **Referral Consent** | | Patient | | Family | | | | **Consent to access medical records** | | | | | Patient | | | | | | Family | |
| **SERVICES REQUIRED – if urgent please telephone 01978 316806 (in hours) or 01978 316800 (out of hours)** | | | | | | | | | | | | | | | | | | | | |
| **Nightingale Inpatient Unit** | | | Symptom Management  EOLC  Emergency Respite  Respite | | | | | | | | | | | | | | | | | |
| **Nightingale Wellbeing Centre**  *To access these services, patients will need to be able to attend onsite appointments* | | | Wellbeing Programme (12 weeks)  Complementary Therapies  Physiotherapy  Psychological Support  Spiritual Support | | | | | | | | | | | | | | | | | |
| **Phase of illness**  *\*see reverse for explanation* | | | Stable  Unstable  Deteriorating  Dying | | | | | | | | | | | | | | | | | |
| **Prognosis:** | | | Blue (Years) | | |  | Green (Months) | | |  | Amber (Weeks) | | | |  | Red (Days) | | | |  |
| **\*Australian Karnofsky Performance Scale (AKPS) USING GUIDANCE BELOW PLEASE INDICATE SCORE ->** | | | | | | | | | | | | | | | | | | **%** | | |
| **100%** Normal, no complaints or evidence of disease. | | | | | | | | | **50%** Considerable assistance and frequent medical or nursing care required. | | | | | | | | | | | |
| **90%** Able to carry on normal activity, minor signs or symptoms of disease. | | | | | | | | | **40%** In bed more than 50% of the time. | | | | | | | | | | | |
| **80%** Normal activity with effort, some signs or symptoms of disease. | | | | | | | | | **30%** Almost completely bedfast. | | | | | | | | | | | |
| **70%** Cares for self, but unable to carry out normal activity or do active work. | | | | | | | | | **20%** Totally bedfast and requiring extensive nursing care by professionals and / or family. | | | | | | | | | | | |
| **60%** Able to care for most needs but requires occasional assistance. | | | | | | | | | **10%** Comatose or barely audible, unable to care for self, requiring hospital care, disease progressing rapidly. | | | | | | | | | | | |

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| **REFERRAL INFORMATION**  **Please attach copies of recent medical correspondence, investigations, results and specialist treatment plans** | | |
| **Main Diagnosis** |  | |
| **Main Diagnosis Summary** including patient’s current condition, severity of symptoms, mobility to assist with appropriate triage |  | |
| **Previous Medical History including treatments received, further treatment planned:**  e.g. Recent admission(s) including date(s) and reason for admission, radiotherapy, chemotherapy etc. |  | |
| Weight: | Height: |
| **Reason for referral:**  *What support do they / their family require including physical, psychological, and spiritual issues.*  *If patient is at home, do they have a POC in place, number of calls and contact details* |  | |
| **Other relevant medical conditions**  *O2 requirement / NIV / PEG / Immunotherapy / ICD Pacemaker* |  | |
| **Infection Control issues**  CDT / MRSA / VRE / Covid |  | |
| **Pressure Areas / Wounds**  Assessment completed, Datix |  | |
| **Current medications and significant recent changes in medications (or send an attachment)** |  | |
| **Known allergies / adverse drug reactions** |  | |
| **Advance Care Planning** | please give detail of any discussions that have already occurred and if any of the following are in place: DOLS / Existing LPA / ADRT / Advance Statement / DNACPR / Preferred Place of Care / Preferred Place of Death / Emergency Health Care Plan. | |
| **Any other services supporting patient,** eg Hospice at Home, District Nurses, Specialist Teams & contact details |  | |

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| **Phase of Illness explanation** | | |
| **Phase of illness** | **This is the current phase if…** | **This phase ends when…** |
| **Stable** | Symptoms are adequately controlled by established plan of care and further interventions to maintain symptom control and quality of life have been planned. Family/carer situation is relatively stable and no new issues are apparent. | The needs of the patient and of family/carer increase, requiring changes to the existing plan of care. |
| **Unstable** | An urgent change in the plan of care or emergency treatment is required because the patient experiences a new problem that was not anticipated in the existing plan of care **and/or** the patient experiences a rapid increase in the severity of a current problem **and/or** family’s/carer’s circumstances change suddenly impacting on patient care. | The new plan of care is in place, has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care. **And/or** death is likely within days. |
| **Deteriorating** | The care plan is addressing anticipated needs but requires periodic review as the patient’s overall functional status is declining and patient is experiencing gradual worsening of existing problems **and/or** the patient experiences a new, but anticipated, problem **and/or** the family/carer experience gradual worsening distress that impacts on the patient care. | Condition plateaus (i.e. patient is now stable) or an urgent change in the care plan or emergency treatment **and/or** family/carers experience a sudden change in their situation that impacts on patient care and urgent intervention is required or death is likely within days. |
| **Dying** | Death is likely within days. | Patient dies **or** patient condition changes and death is no longer likely within days. |

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| ***To be completed by NHH Staff only*** | |
| Date received: |  |
| NHH Referral Number: |  |
| Referral Spreadsheet: |  |
| Date of NHH Contact: |  |
| Caseholder: |  |
| Triaged by: |  |
| Triage Outcome: |  |
| Patient Demographics: |  |
| Pre-Admission Form: |  |
| Ward Handover complete: |  |
| Clinical Admin Patient file setup: |  |
| NHH Patient Number: |  |
| Clinical Admin – invite letter sent (if appropriate): |  |