Focus on Living Referral Form

Title	Surname		First name	Preferred name
DOB	**Age**	**Gender**	**NHS/MRN No:**	**Date of Referral**
Address **Postcode**			**Telephone Number**	**Lives alone** Yes ☐ No ☐
			Ethnic Group	**Religion**
			Interpreter required? Yes ☐ No ☐	
NOK details / Main carer: **Full name** **Address** **Telephone Number (mobile)** **Relationship**			**Referred by:** **Designation** **Contact** **Consent agreed for referral** Yes ☐ No ☐ * Please note - referral will not be accepted if patient or main carer has not consented to referral.	
Diagnosis Primary: Secondary: **Date**			**GP** **Address** **Telephone Number**	

Other professionals involved if known (e.g. GP, Macmillan/District Nurse, Consultant, Social Services, Psychology, OT, Physiotherapist)			
Professional	Telephone Number	**Professional**	Telephone Number
Professional	Telephone Number	**Professional**	Telephone Number

Advanced decisions/statements	
EHCP Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
LPA Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
DNACPR Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
Any other advanced decisions/statements completed or disclosed.	

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Reason for referral:	
☐ **Pain /Symptom management** (please specify, e.g. breathlessness, fatigue, etc)	
☐ **Psychological/ Emotional /Spiritual Support** (please specify, e.g. low mood, stress, anxiety etc)	
☐ **Social Support** (please specify, e.g. housing, financial and legal issues, care planning etc)	
☐ **Ambulatory Care (Infusion)** – Please state:	☐ **Ambulatory Care (Blood Transfusion**) – Please complete specific section at the end of this form.
☐ Other (please specify)	

Relevant medical history, including medication, allergies and any current nursing interventions.
Any cognitive impairment and/or sensory impairment. If yes, please provide relevant information. **Can Mental Capacity be assumed? If No- what is the reason for needing to assess capacity?**
Any communication difficulties, e.g. hearing or speech impairment
Mobility Status e.g., independent, assistance, wheelchair
Any there any other risk factors that we should be aware of

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St Oswald's Hospice

Blood Transfusion Only - Please complete the section below:

Has patient been consented for transfusion within the past year? Yes ☐ No ☐		If No: Please refer to blood transfusion request form and complete consent.	
Indication for transfusion			
Current Hb g/L		Target Hb g/L	
Number of units required/duration to be given			
Does the patient require and special requirements?		☐ Irradiated	☐ CMV negative (pregnant/neonates)
		☐ Other – please state	
Is there a risk of Transfusion Associated Circulatory Overload? Yes ☐ No ☐			
TACO Checklist Cardiac history/on regular diuretic: Yes ☐ No ☐		Pulmonary Oedema/SDOB Yes ☐ No ☐ Positive Fluid Balance/Pedal oedema Yes ☐ No ☐	
Are additional Medicines required? Yes ☐ No ☐		Please indicate: Antipyretic/Antihistamine/Diuretic/Other	

Please complete and return this referral form to: necne.referrals@nhs.net