***If you wish to refer to the Wyre Forest Community Specialist Palliative Care Team please contact them directly using these details:***

**Tel: 01527 488064 / Email:** **whcnhs.communityspcnorth@nhs.net**



 Return to: **KEMP Hospice, 41 Mason Road**

 **Kidderminster, DY11 6AG**

 **01562 756000**

**care.8c884@nhs.net**

**Guidelines for Referral to KEMP Hospice’s Day Services**

KEMP Hospice offers day services at the Hospice and also outreaching services into the community.

We support patients who are 18 years and over who have a palliative diagnosis of a life-limiting illness and are registered with a Wyre Forest GP.

Our team comprises Palliative Nursing Team, Occupational Therapy, Exercise and Well-being Services, Complementary therapy, Finance and Welfare Advice and Creative Arts.

**Our services operate Monday to Friday 8:30–16:30, except for bank holidays and a Christmas Holiday closure.**

**Referral Criteria:**

If you are unsure if the patient meets the criteria, please phone to discuss with a member of the nursing team.

* Adult - 18 years and over, registered with a Wyre Forest or Tenbury Wells GP
* Diagnosis of progressive life-threatening illness (Essential Criteria).
* Palliative care needs that cannot be met fully by current health/ social care professionals.
* Well, enough to engage and benefit from KEMP services on-site at the Hospice\* or in their own homes.
* Patient has consented to KEMP’s involvement.

\**For attending on-site, patients must be able to be transported to the KEMP Hospice safely - ambulance transport can be arranged through KEMP or private transport arranged by the patient (friends, family, specialist taxi)*

**Referrals are accepted for:**

* Symptom control
* Complex psychological and/or social needs
* Finance & Welfare Assessment
* Rehabilitation / Therapy intervention / support to help maintain function and wellbeing.
* Difficulty coping with a potentially life-threatening illness.
* Advance Care Planning support, including ReSPECT.

*Referrals may also be made for single therapies rather than the full MDT Hospice input – please see the options available on the referral form.*

**Who can refer:**

* Referrals may be made by General Practitioners or other Health or Social Care professionals.
* They may also be initiated by the patient or a family member or an LPA for health and welfare.

*It is recommended that the referrer informs the GP of the referral in advance. KEMP Hospice will notify the GP when a referral is made.*

**How to refer:**

* Referral is by completion of a KEMP Hospice referral form – via our website www.kemphospice.org.

**Reasons for not accepting referrals / discharge from service:**

* Outstanding needs do not fall within the KEMP Hospice criteria.
* The patient is not well enough to benefit or access KEMP services - KEMP will signpost to other services as appropriate.
* Discharge will be arranged when the needs of the patient are more appropriately met by other health or social care professionals, or both.
* The patient no longer wishes to attend.
* The patient has stabilised and no longer requires hospice services.
* Completion of 12-week program of support and no further needs for support identified.

*KEMP Hospice will send a letter to the referrer informing of any decision to not accept or to discharge and the reasons.*

**Referral to KEMP Hospice Care Services**

|  |  |
| --- | --- |
| **PATIENT CONSENT - Is the patient aware of the referral and agrees to participate with information being shared with other professionals?** | **YES / NO** |

**All sections of this form must be completed in order for your referral to be processed and consent MUST be gained prior to referral.**

**Day Hospice Service(s) Required (please tick): Outpatient Service(s) Required (please tick):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nursing –** Palliative assess & support |  |  | **Breathlessness**  |  |
| **Occupational Therapy** |  |  | **Relaxation** |  |
| **Complementary Therapy** |  |  | **Parkinson’s / Neuro exercise** |  |
| **Creative Arts**  |  |  | **Parkinson’s / Neuro Maintenance Seated Exercise VIRTUAL** |  |
| **Psychosocial Support** |  |  | **Strength & Balance / Falls Prevention** |  |
| **Finance & Welfare** |  |  | **Carer’s Group** |  |
|  |  |  | **Care Home Support -** please call nursing team to discuss need |  |

|  |
| --- |
| **Patient Details** |
| **Full legal name of PATIENT** |  |
| **Date of Birth** |  | **NHS Number** |  |
| **Address *(including postcode)*** |  |
| **Contact Number(s)*****Please indicate preferred number*** |  |
| **Email Address** |  |
| **Communication Needs:** Who should we contact in the first instance if not the patient? | **Name:** | **Relationship:** | **Telephone:** |
| **Next of Kin** ***Please indicate if the next of kin has Lasting Power of Attorney:**** health and welfare property Y/N
* financial affairs Y/N
 | **Name:** | **Relationship:** | **Telephone:** |

**Assessment & Review:**

* We will aim to send a letter to the patient in response to the referral within 5 working days. Then a member of the care team will make contact to arrange the initial assessment. If the referral is urgent, please phone and discuss it with a member of the nursing team.
* The initial assessment will usually be with a member of the nursing team at the patient’s home where services will be explained in more detail.
* Patients are continually supported by the multi-disciplinary team to set personal goals over a 12-week period and at the KEMP Multi-disciplinary team meetings.
* The Care Services Team will liaise with the patients GP and other health and social care professionals as appropriate, in the hospice, community or hospital.
* Support can be arranged for significant others – see ‘Support for Carers’ on page three.

|  |
| --- |
| **Safeguarding** |
| Are there any safeguarding concerns with this patient? **If you prefer to discuss this by telephone, please call 01562 756000 and ask for the Care Services Manager** |  |

|  |
| --- |
| **Referral Reasons – (Please look back at our services on offer at the start of this form)** |
| Diagnosis |  |
| Symptoms |  |
| Therapy Needs |  |
| Emotional / social / spiritual needs related to diagnosis |  |

|  |
| --- |
| **Other Professionals Involved** (e.g. Consultant, Social Worker, Macmillan Nurse, Specialist Nurse, Psychologist) |
| Name | Role | Contact Number |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Support for Carers** |
| **If the patient has a significant carer / family member who acts as their main carer who would benefit from support, please ensure you tick the Carer’s Group in Outpatient Services and write the carer’s details below. The carer would need to be added to our records, so we require sufficient detail to locate them.** |
| **Carer’s Full LEGAL Name** | **Carer’s Date of Birth** **Carer’s NHS Number** | **Summary of need** |

|  |
| --- |
| **Referrer Details** |
| **Name** |  |
| **Role** |  |
| **Contact Details** |  |
| **Signature** |  |
| **Date** |  |

**\* Please email this completed form to** care.8c884@nhs.net **\***