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| NHI | |
| SURNAME NAME/S |  |
| Address & Postcode | |
| Tel: | |
| DOB: | age |
| Name of Practitioner | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Referrer’s Name: | |  | | | | | |
| Service: | |  | | | | | |
| Referrer’s Phone number/s: | |  | | | | | |
| Date of Referral: | |  | | | | | |
| Hospice Overnight Care [10pm to 8 am]  required in what timeframe: | | ASAP  24 hrs  Other  *(specify)* | | | | | |
| Frequency of care requested: | | 1 night per week 2 consecutive nights  Other  *(specify)* | | | | | |
| Patient is aware of this referral: | | *(anything else to specify)* | | | | | |
|  | | | | | | | |
| PATIENT CONSENT: | | | | | | | |
|  | | | | | Yes |  | No |
| I have received information about the services offered to me and have had questions answered.  I consent to the proposed care, support and risks (if any) as explained. | | | | |  |  |  |
|  | | | | |  |  |  |
| I understand it is my right to make informed choices and give informed consent.  I understand that I am welcome to seek more information at any time. | | | | |  |  |  |
|  | | | | |  |  |  |
| I understand that my confidentiality is protected by everyone at hospice to comply with the standards in the ‘The Code of Health and Disability Services Consumers’ Rights’.  I give permission for information to be shared between health professionals, such as consultants and specialists, Palliative Care Team and General Practitioner. | | | | |  |  |  |
|  | | | | |  |  |  |
| Patient Name: |  | | Signature: |  | | | |
| Or Next of Kin: |  | | Signature: |  | | | |
| Date: |  | | | | | | |
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| PATIENT DETAILS: | | | | | | | | |
| Diagnosis / relevant medical history: | | |  | | | | | |
| Ethnicity: | | |  | | NZ Resident: | |  | |
| Language spoken at home: | | |  | | Interpreter Required: | |  | |
| Is language / communication assistance required? | | | *(specify)* | | | | | |
| Cultural / Spiritual needs *(Iwi, Pacifica, etc)* : | | |  | | | | | |
| Living Situation: | | |  | | | | | |
| Palliative Care phase: | | | Deteriorating | *There is gradual worsening of symptoms. There is regular review but no urgent or emergency treatment.* | | | |  |
| End-of-life | *Death is likely in a matter of days. No acute intervention is planned or required.* | | | |  |
| Palliative Performance Scale (PPS)  or AKPS: | | |  | | |
|  | | | | | | | | |
| ELIGIBILITY CRITERIA: | | | | | | | | |
|  | Patient has expressed a wish to remain at home for as long as possible, even through to death (verbal or within Advance Care Plan) | | | | | | | |
| AND | | | | | | | | |
|  | Patient is nearing end-of-life | | | | | | | |
| AND | | | | | | | | |
|  | Functional ability is ≤ 40% (PPS/AKPS) but may be changeable | | | | | | | |
| AND ANY OF THE FOLLOWING | | | | | | | | |
|  | Family / whānau / carers are physically or emotionally unable to continue the caring of their loved one without support | | | | | | | |
|  | There is limited family support | | | | | | | |
|  | Carer stress is high. | | | | | | | |
|  | There are specific cultural / spiritual issues necessitating extra support | | | | | | | |
|  | | | | | | | | |
| CARER / FAMILY DETAILS: | | | | | | | | |
| Marital Status / Family Relationships / Children *(Ages)*: | |  | | | | | | |
| Is there a carer? | |  | | | Relationship to patient: | |  | |
| Name of carer: | |  | | | | | | |
| Sex of carer: | |  | | | Age of carer: | |  | |
| Phone *(mobile / landline)*: | |  | | | | | | |
| Is carer able to assist with physical care? | | *(details)* | | | | | | |

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| DESCRIPTION OF ASSISTANCE TO BE PROVIDED BY HOSPICE ASSISTANT: | | |
| Manual handling: |  | *(details, Aids, equipment)* |
| Mobility: |  | Bed bound  Swivel transfer  Walk  *(details)* |
| Continence management / toileting: |  | *(details, Aids)* |
| Personal hygiene: |  | *(details)* |
| Pressure Area care: |  | *(details)* |
| Other care: |  | *(details)* |
| Other information relevant to care: |  | |

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| HOME ENVIRONMENT CHECKLIST: | | | | | | | | |
| *The home environment checklist is to be completed for all referrals to identify key risks.* | | | | | | | | |
| Date of home environment check: |  | | | | | | | |
| Service you work in: | District Nursing  Palliative Care  Hospice  Other | | | | | | | |
| Parking availability at patient’s home. |  | | *(details)* | | | | | |
| OUTSIDE – gates easy to open. Pathways, steps, verandas are level, non-slip, uncluttered. |  | | *(details)* | | | | | |
| OUTSIDE lighting adequate at night. |  | | *(details)* | | | | | |
| Pets, dog outside – are they friendly / restrained? |  | | *(indicate type of pet, pets name)* | | | | | |
| Location of main entrance door: | Front  Side  Back  *(other details)* | | | | | | | |
| INSIDE – floor surfaces are level, non-slip, uncluttered. Lighting is adequate for performing work. |  | | *(details)* | | | | | |
| INSIDE – adequate warmth for Hospice assistant to work in overnight. |  | | *(details)* | | | | | |
| BATHROOM – easy to access for patient. Equipment in place if required e.g. toilet raiser, commode with or without wheels. |  | | *(details)* | | | | | |
| BEDROOM – sufficient space around bed, uncluttered floor space. |  | | *(details)* | | | | | |
| BEDROOM – bed is at suitable height for working with patient. |  | | *(details)* | | | | | |
| Gloves / other protection is available if required. |  | | *(details)* | | | | | |
| Carer / family member is aware they have to be present in the house. |  | | *(details)* | | | | | |
| Patient is: | Smoker  Non-smoker | | | *(any details)* | | | | |
| Carer / family members / others smoking in the house? | *(details)* | | | | | | | |
| Does the patient show signs / behaviours that indicate resistance to care? |  | | *(details)* | | | | | |
| Is the patient able to accept instructions / cognitively understands? |  | | *(details)* | | | | | |
| Is there an identified infection risk? |  | | *(details)* | | | | | |
| Is landline telephone available? |  | | Is there CELL PHONE coverage? | |  | *(details)* | | |
| Comments / additional information: |  | | | | | | | |
| CHECK LIST COMPLETED BY: | | SIGNATURE: | | | | | DESIGNATION: | DATE: |
|  | |  | | | | |  |  |

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| EMAIL TO: Hospice South Canterbury nurses@hospicesc.org.nz |

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| OFFICE USE: | | | | |
| Hospice Care Overnight referral has been accepted: |  | | | |
| Frequency (e.g. 1 night weekly, 2 nights weekly) |  | | | |
| To commence when: |  | | | |
| Name of Hospice Assistant allocated: |  | | | |
| NAME OF SENIOR HOSPICE RN: | | SIGNATURE: | DESIGNATION: | DATE: |
|  | |  |  |  |