



**j. Nursing care required** Yes No

Personal Hygiene		
Mouthcare		
Pressure area care		
Assessment of nursing care		
Wound care (dressing)		
Any known infections (e.g. MRSA)		
Continent bowels		
Continent bladder		
Urostomy		
Colostomy		
Ileostomy		
Catheterised		
Patient at risk of falling		

**k. Communication:**

Does the patient have any problems with:

Hearing		Speech	
Eyesight		Co-ordination	
Patient's first language	English		Other

**j. Psychological support:** Yes No

Is the patient suffering from depression?		
Relevant mental health history		

**l. Religion:**

Patient's Religion?
Special practice to follow?

**m. Moving & handling:** Yes No

Is moving and handling equipment provided?		
Details:		
Is all relevant nursing equipment provided?		
Details:		

**n. Other significant information:** Yes No

Pets in home?		
Details if known?		
Smoking in the home?		
Patient    Family    Carers		
Alcohol misuse in the home?		
Patient    Family    Carers		
Physical/verbal aggression in the home?		
Patient    Family    Carers		
Patient lives alone?		
If yes, how to gain access into the home?		
Are there any concerns about the area?		
If yes, give details:		
Are there any difficult family circumstances?		
Anxious family?		
Significant ill health in family/carers?		
Other details:		

**o. Additional nursing care information:**

Details:
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**p. Other agencies providing care:**

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**q. Overnight service required?** Yes No

Details:		

**Details of referrer:**

<b>Name</b>	
<b>Title</b>	
<b>Location</b>	
<b>Tel</b>	
<b>Signature</b>	

Please fax **PAGES 1 & 2** to the  
**Inpatient Unit at St Mary's Hospice:**  
**Fax 01229 583 072**



### a. Patient details

Title	Mr / Mrs / Miss / Ms / Dr / other		
Forename			
Surname			
Address			
Post code			
Tel			
DOB			
Cancer		Non Cancer	

### b. Primary carer details (next of kin)

Name	
Relationship	
Tel	

### c. Healthcare provider details

GP name	
GP tel	
DN name	
DN base no.	
DN mobile no	
Any other no e.g. out of hours	

### d. Nursing assessment

	Yes	No
Care plan available in home?		
Medication chart available in home?		
Assessments completed including manual handling?		
<b>Yes No</b>		
DNR status recorded?		
Is the patient for resuscitation?		
Does the patient have an ICD?		
Is the ICD deactivated?		

### e. Diagnosis

Primary diagnosis	
Secondary diagnosis	

### f. Prognosis

Months	Weeks	Days	Imminent
Is patient on a care pathway? e.g. LCP			Yes No
Additional relevant past medical history			

### g. Patient/carers awareness

	Yes	No
Is the patient aware of diagnosis?		
Is the patient aware of prognosis?		
Is the carer aware of diagnosis?		
Is the carer aware of prognosis?		

### h. Medication

	Yes	No					
Does the patient have a syringe driver?							
Is there 24 hour DN cover?							
<b>Route of medication</b>							
Oral		Injection		PEG		Other	
<b>Additional Information</b>							
Suction		Oxygen		Other			
<b>Who administers medication?</b>							
Patient		Carer		Other			
<b>Yes No</b>							
Does the patient require breakthrough medication?							
Is it prescribed and in the home?							

### Any other information

### i. Symptoms

Patient alert		Semi conscious	
Conscious		Unconscious	
Any additional information			