**EPaCCS Referral Electronic Palliative Care Coordination System**

Patient’s details:

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Known as: |  |
| Date of birth: |  | NHS number: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender | Male: | [ ]  | Gender Identity | Male: | [ ]  |
| Female: | [ ]  | Female: | [ ]  |
| Choose not to disclose: | [ ]  | Non-binary: | [ ]  |
| Transgender: | [ ]  |
| Other: |  |
| Religion/ beliefs: |  | Preferred Pronouns: |  |

|  |  |
| --- | --- |
| Home Address: |  |
|  |
|  |
| Postcode: |  |
| Telephone numbers: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First language(s) and or preferred method of communication: |  | Interpreter required: | Yes [ ]  No [ ]  |
|  |

Consent:

|  |
| --- |
| I am the patient and I consent to being referred to EPaCCS Yes [ ]  I am the child’s parent / carer (or those with parental responsibility) and consent to the referral Yes [ ] I am the patients representative consenting on their behalf Yes [ ]  If completing this on behalf of patient, please state your relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the child/young person / family agree to share their health electronic care record? (*This helps to review the most up to date clinical information about the child or young person*) Yes [ ]  No [ ]   |

Referrer’s details

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Email: |  |
| Relationship to patient: |  | Date of referral: |  |
| Job title |  | Organisation: |  |
| Telephone numbers: |  | Email: |  |

Current family details:

|  |  |  |
| --- | --- | --- |
| Parent / Carer |  | Parent / Carer  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  |  | Telephone: |  |
| Email: |  |  | Email: |  |
| Gender Identity | Male: |  | Female: |  |  | Gender Identity | Male: |  | Female: |  |
| Non-binary: |  | Other: |  | Non-binary: |  | Other: |
| Preferred Pronouns: |  |  | Preferred Pronouns: |  |
| Relationship to patient: |  |  | Relationship to patient: |  |
| Do they have a disability? |  |  | Do they have a disability? |  |
| Ethnic group: |  |  | Ethnic group: |  |
| Main language(s): |  |  | Main language(s): |  |
| Interpreter required? | Yes | [ ]  |  | Interpreter required? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Do they read English? | Yes | [ ]  |  | Do they read English? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If not, how do they communicate? |  |  | If not, how do they communicate? |  |
| Do they have parental responsibility? | Yes | [ ]  |  | Do they have parental responsibility? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If no, who has parental responsibility? |  |  | If no, who has parental responsibility? |  |
| What are their contact details? |  |  | What are their contact details? |  |

EPaCCS information:

|  |
| --- |
| Is there a ReSPECT document in place? Yes [ ]  No [ ]   |
| Have any advance care planning discussions taken place? Yes [ ]  No [ ]   |
| Advance care plan details:*Date signed etc* |  |

|  |
| --- |
| Resus Status: |
|  [ ]  Not for resuscitation [ ]  For resuscitation [ ]  For modified resuscitation  |

|  |
| --- |
| PPC: |
|  [ ]  Home [ ]  Hospice [ ]  Hospital [ ]  Relative’s home  |
| PPD: |
|   [ ]  Home [ ]  Hospice [ ]  Hospital  |

|  |
| --- |
| Is there an emergency care plan? Yes [ ]  No [ ]  *If no official plan, please detail below – are they 999 intervention admission to the hospital in an event of an emergency etc?* |
| Discussion about emergency health care plan: |  |

|  |  |
| --- | --- |
| Symptom Management Plan:*Date signed, hospital etc*  |  |

Additional information such as any relevant current family circumstances:

|  |
| --- |
|  |

**Please complete this form in full with as much detail as possible, and send via a secure email to Little Havens at****havenshospices.lhipu@nhs.net**