**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**](mailto:havenshospices.lhipu@nhs.net)