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

|  |  |
| --- | --- |
| 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: |       |
|  |

|  |
| --- |
| 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)*       |

|  |
| --- |
| 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: |       |

|  |
| --- |
| 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: |
|       |       |       |       |

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

|  |
| --- |
| 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: |
|       |       |       |       |