LEWIS-MANNING HOSPICE CARE DAY HOSPICE REFERRAL FORM

Please fill out this form and EMAIL or POST to Lewis-Manning Hospice Care.

Post to: Nursing Staff, Lewis-Manning Hospice Care, 1 Crichel Mount Rd, Lilliput, Poole, Dorset, BH14 8LT
Tel: 01202 708470
Email: referral forms to admissions.lewismanning@nhs.net

Date of Referral: ……

ELIGIBILITY CRITERIA FOR DAY HOSPICE AND REFERRAL INFORMATION
Lewis-Manning Day Hospice is a small friendly unit that caters for people who are over the age of 18 years, living with a life limiting disease, such as Cancer, Neurological conditions such as Motor Neurone Disease, Multiple Sclerosis, Progressive Supranuclear Palsy and Parkinsons Disease. Some of our patients also suffer from specific lung conditions. We are not a specialist unit for people with dementia. We are able to offer a 3 month programme for patients with an expectation that individuals can be re-referred back to us after a 3 – 4 month break. Patients usually attend the same day each week. Day Hospice is open from 10am to 3pm. There is an activity coordinator available on most days. Referring Health Care Professionals should try and complete as many sections as possible. If any sections are incomplete we may need to contact you. **Please write clearly**. We accept patients from all the around Poole area. We reserve the right not to accept a patient onto a programme if we do not think they are suitable for our facility. If you are unsure, please phone **01202 708470** and speak with the Day Hospice Team Leader or their Deputy. Please note, Lewis-Manning Hospice is strictly a **NO SMOKING SITE**

1. ESSENTIAL PATIENT INFORMATION		
Patient's Name	**Patient Address with Post Code**	**Telephone Number:**
		Mobile Number:
Date of Birth:	**NHS Number:**	**Patient aware of referral:** **Yes** ☐ **No** ☐

2. PATIENT'S GP (Address and telephone number)

GP aware of referral Yes ☐ No ☐

3. MAIN CARER:

Name & Relationship to Patient	Relationship to Patient	Contact Number

4. REFERRED BY

Name and Position	Contact Number	Signature & Date
Key Contact/Liaison Health Professional		

5. CURRENT HOSPITAL CONSULTANT(S)

6. OTHERS INVOLVED	(name and phone number where possible)
• **District Nurses**	
• **Specialist Nurse/Community Matron**	
• **Allied Health Professional**	
• **Social Services/Key Worker**	
• **Other**	

Patient's name: . . . . . .

7. DIAGNOSIS AND HISTORY OF THIS ILLNESS

• **Diagnosis**	**Patient Aware Yes ☐ No ☐** **Patient Aware of End of Life stage Yes ☐ No ☐**
• **Relevant Medical History**	

- **Relevant treatment and management to date**

- **Current Medication**

- **Allergies/Dietary Needs**

- **Pacemaker** **Yes** ☐ **No** ☐

- **Known infections**

- **Relevant Family/Social History**

8. IS THE PATIENT AWARE THEY ARE BEING REFFERED?

9. REASON FOR REFERRAL TO LEWIS-MANNING HOSPICE

10. THIS SECTION MUST BE COMPLETED BY REFERRER

Does Patient have: Advance Decision (previously known as Living Will) Yes ☐ No ☐

Advance Statement Yes ☐ No ☐

Resuscitation Status Please specify . . . . . .

Preferred choices at end of life, if known Please specify . . . . . .

11. The following information is required for the health and safety of the Patient, Lewis-Manning Staff and Volunteers, prior to a Patient attending an initial assessment at the Day Hospice

Transport

1. Will Patient need Volunteer Transport for first Assessment Visit to Lewis-Manning Hospice?
Yes ☐ No ☐

2. Is Patient independently mobile?
Yes ☐ No ☐

If No, please give details of assistance required and aids used: . . . . . .

. . . . . .
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. . . . . .

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3. If Yes, please tick section below:

Deafness ☐ Visual impairment ☐ Confusion/memory problems ☐
Balance problems ☐ Co-ordination/spasm/paralysis ☐ Pain on movement ☐
Oedema ☐ Anxiety ☐ Obesity ☐ Breathlessness ☐

Access to Lewis-Manning is via 3 steps or 10 metre slope to front door

Is Patient able to manage steps Yes ☐ No ☐ Independent Yes ☐ No ☐
Is Patient able to manage slope Yes ☐ No ☐ Independent Yes ☐ No ☐

Level walking distance manageable 10 metre minimum Independent Yes ☐ No ☐

TO BE COMPLETED FOR ALL PATIENTS PLEASE

Physical/Nursing Care

Elimination needs? Independent Yes ☐ No ☐
If no, details of assistance required . . . . . .

Catheter/Colostomy Yes ☐ No ☐
If yes, details of any assistance required . . . . . .

Details of any wounds that may require treatment . . . . . .

Special dietary requirements Please specify . . . . . .

Other . . . . . .

Medication Assistance? Eye drops, etc: . . . . . .