Referral for Supportive Care Admission

Our Lady's Hospice & Care Services
Anna Gaynor House, Harold's Cross, Dublin 6W

Harold's Cross
Blackrock
Wicklow
Respite Rehabilitation Reassurance

ADMISSION CRITERIA FOR SUPPORTIVE CARE BEDS:

- Patients who are frail with an active progressive illness and an estimated prognosis of **less than 6 months.**
- Older people who have palliative care needs that **cannot be met** in their own home.
- **Advance care planning** with the patient and medical team must take place prior to referral.
- Referrals are only accepted from **Palliative Medicine** and **Geriatrician** Consultants.
- NHSS funding **is not required** prior to referral or admission to Anna Gaynor House, however patients & families must be made aware that they will have to start the process 16 weeks post admission if their prognosis changes or improves. A **consent form/agreement must be signed** by the patient /family following this discussion that they agree to engage with the NHSS funding process and it must be **sent with the referral (see Agreement for the Supportive Care Pathway form)**.

PART 1 - PATIENT INFORMATION	
Surname:	
Forename(s):	
Home address and telephone number:	
Current location:	
Date of birth:	
First point of contact:	
Relationship to patient:	
Home address and telephone number:	
Name of GP, address and telephone number:	

PART 2 - MEDICAL INFORMATION

Including diagnosis, and extent of illness:

Is the patient on any Specialist ☐ High Tech ☐ Unlicensed medicines ☐ Medicines requiring any specialist devices/equipment or requiring specialist monitoring ☐ ? (If these medications are to be continued please specify so we can ensure continual supply on admission):

Has **resuscitation** been discussed A) With patient? Yes ☐ No ☐ B) With relative? Yes ☐ No ☐
If No to A or B please give reasons:

Have **ceilings of treatment** been discussed A) With patient? Yes ☐ No ☐ B) With relative? Yes ☐ No ☐
If No to A or B please give reasons:

Outcome of discussions (please specify ceilings of care discussion and patient/family's understanding):

NHSS funding process discussed? A) With patient? Yes ☐ No ☐ B) With relative? Yes ☐ No ☐
Consent form signed and attached? Yes ☐ No ☐

Date of onset of illness:	Estimated prognosis:____Weeks,___Months,___Years

Department of Health Classification		Please tick ✓
Low dependency:	Needs some support, but little nursing care, independently mobile +/- a walking stick.	
Medium dependency:	Requires residential care. Requires supervision mobilising or a walking aid.	
High dependency:	Requires residential care, is not bed-bound. May have physical and mental disabilities, may be confused at times, or be incontinent. Requires a walking aid and physical assistance to walk.	
Maximum dependency:	Requires nursing care, is bed-bound, requires assistance with all aspects of physical care. May be ambulant, but confused, disturbed and incontinent.	

Additional Support Requirements		Patient Choice	
Does this patient require enhanced supervision?	Yes ☐ No ☐	Is the patient aware of this referral?	Yes ☐ No ☐
Is this patient at risk of absconsion/ exit seeking?	Yes ☐ No ☐	Is the family aware of this referral?	Yes ☐ No ☐

Infection

Does this patient have a history of infection? (MRSA, C.Difficile, VRE, CPE, CRE or other):

Has the patient received their COVID vaccinations? Dose 1 ☐ Dose 2 ☐ Booster 1 ☐ Booster 2 ☐ Booster 3 ☐

Have they had COVID in the past 4 months? Yes ☐ No ☐

Referrer's name: (BLOCK CAPITALS) Referrer's signature:	Signature of Consultant:
Address: Contact number(s):	Date:

***** Please attach copies of recent correspondence, imaging reports and blood results. *****