**Respite Referral Form for Patients** 

1. **Personal Details of the person requiring respite care**

**Name.................................................................................Date of Birth......................................**

**Address........................................................................................................................................**

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

**Telephone Number...............................................Mobile Number...............................................**

**Current location of the person eg. Home / care home / hospital**

**Who does the person live with?...................................................................................................**

**Ethnicity................................................................Religion...........................................................**

**Current registered GP...................................................................................................................**

***I give permission for the hospice to contact my GP regarding this request, and access my GP shared record***  ***☐***

1. **Carer details - please supply information of your unpaid carer, who may also be a family member or your next of kin:**

**Name.............................................................Relationship to patient...........................................**

**Address........................................................................................................................................**

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

**Contact telephone number..........................................................................................................**

**Details of any current care package in place (care that is paid, even if not directly paid for by you)…..........................................................................................................................................**

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

**How does your carer help you?....................................................................................................**

**....................................................................................................................................................**

…..........................................................................................................................................................

1. **Health Information**

**Please tell us about any current health problems you have / current diagnosis:**

**Are you currently having any treatment for your health problems? Y / N**

**If Y, please give detail:…...............................................................................................................**

…...........................................................................................................................................................

**Have you previously had any other medical problems? Y / N** (Please list if applicable)

**....................................................................................................................................................**

**…..................................................................................................................................................**

**Do you use any equipment to help with breathing** (e.g non-invasive ventilation (NIV); Bi-level Positive

Airway Pressure Ventilation (BiPAP), Continuous Positive Airway Pressure Ventilation (CPAP), oxygen, nebuliser) Y / N (please list if applicable) **…...............................................................................**

**…..................................................................................................................................................**

**Do you have any food or medication allergies? Y / N** (If Y please specify) …................................

**.....................................................................................................................................................**

**Have you had your seasonal flu vaccination? Y / N** If Y, date administered:…..............................

**Have you had your Covid-19 vaccination?**  **Y / N** If Y, date administered:.................................

**Any other relevant information?.................................................................................................**

**…..................................................................................................................................................**

1. **Respite request**

**Which week would you like to request?** (please note only 1 week can be requested at a time, a maximum

of 3 months in advance. Respite weeks are offered Thursday to Thursday).

**Is there an alternative week/flexibility in the dates? Y / N** (If Y, please specify)

**Do you have your own transport to and from the hospice? Y / N**

**Is this respite request for:**

* **Carer break**  **☐**
* **Rehabilitation goals**  **☐**
* **Advance care planning**  **☐**
1. **Who is completing this form?**

**Patient ☐** **Other**  **☐** **Name.......................................Relationship to patient....................**

**Contact details......................................................................Date of referral................................**

Upon completion, please email this form to cmicb-cheshire.echospicerespite@nhs.net

***For ECH use:***

***Date of receipt:*** ***By:*** ***EMIS record created:*** ***EMIS number:***