The Prince & Princess of Wales Hospice

Access, Referral and Admissions to Hospice Services

Policy and Procedures

Policy No: CL001-R1

Policy Leads	Dr Alistair McKeown Dr. Rachel Kemp
Working Group (if applicable)	Jackie Husband Audra Cook
Date submitted for Ratification	24th February 2014
Date Ratified	14/04/14
Signature and Designation of Ratifier 1	Lorna MacIntyre, Director of HR and Volunteering
Signature and Designation of Ratifier 2	Rhona Baillie, CEO
Date of issue:	14/04/14
Frequency of review	Every 3 years

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Distribution of copies:

1. **Clinical Administration Office**
2. **Inpatient Unit**
3. **Day Services**
4. **Library**

This document is located in the above areas for staff to read.

This document has been read and understood by the following personnel:

Multidisciplinary clinical teams
Clinical administration team

1. Policy

The services of the Hospice provide care by complementing existing health care services with an appropriate level of intervention for the needs of the individual and their carers.
The aims of the policy are to clarify the criteria for access and provide formal processes for the referring agents. It also will clarify the criteria for admission to the individual services and provide clear guidance for the acceptance and administration of referrals.

Service provision

- The Prince & Princess of Wales Hospice offers specialist palliative care for patients with advanced and progressive disease, irrespective of underlying diagnosis. The services at the Hospice are available to those individuals aged 18 years and over with complex problems associated with a life-limiting disease and where a progressive decline is evident. Referrals for patients aged 15 years and over will be considered on an individualised basis as part of the Hospice's development of a transitional care model.

- Complex problems are defined as those which are severe and intractable and have persisted after assessment and/or intervention by generalists. These complex problems can include physical, psychosocial, emotional or spiritual distress. Access to the services is for those who reside primarily in the given catchment areas of the south side of Glasgow, East Renfrewshire or Cambuslang and Rutherglen, although an out of area referral may be considered on an individual basis.

- A range of services are available including: multi-disciplinary in-patient care (14 beds); community based palliative care services which include the multi-disciplinary community team; a family support service; and out-patient services which include day services, out-patient clinics and specific programmes of care.

- If deemed appropriate, a patient referred to any of our services will have the opportunity to be assessed by a range of palliative care specialists including medical and nursing staff, complementary therapists, pharmacist, physiotherapist, occupational therapist, chaplain, social worker, counsellors and resident artists.

- The service offers specialist palliative care advice and support to local hospitals (Victoria Infirmary, Southern General Hospital and Mearnskirk Hospital) with input from a specialist palliative care medical consultant.

- Access to Hospice services is not open ended. Patients who access Hospice services will be reviewed regularly by the multidisciplinary team and may be discharged if needs are met (in accordance with the Hospice's discharge policy). The Prince & Princess of Wales Hospice is unable to offer longer term continuing care for those without specialist palliative care needs.

- Specialist palliative care nursing and medical advice for health and social care professionals is available 24 hours a day, 7 days a week.

- Service provision is in accordance with the criteria within the National Care Standards (Hospice Care), the NHS QIS Standards for Specialist Palliative Care, Clinical Governance & Risk Management and Greater Glasgow and Clyde NHS Service Agreement for Hospice Services.

2 Responsibility/Accountability

Ultimate Responsibility:	Chief Executive
Line/Departmental Responsibility:	Lead Consultant/Director of Clinical Services
Individual Responsibility:	Clinical teams

3. Related Hospice Policies

1. CL002: Consent to treatment policy
2. C015: Protecting patient confidentiality policy
3. IG003: Management of patient information policy
4. CL005: Cardio pulmonary resuscitation policy
5. C002: Infection control policy and manual
6. C017 Complaints, comments and suggestions policy
7. C005 Protection of vulnerable adults policy
8. CL006 Discharge from Hospice services policy
9. CL019: Transfer of patients in the Hospice ambulance policy
10. C009: Moving and positioning policy
11. HR003: Lone working policy

4. Procedure(s)

4.1: Accessing the services

4.1(a) Criteria for access to Hospice services:

Essential:

- The referral has been discussed by the referrer with the patient (or guardian) who agrees for the referral to hospice services
- A completed referral form is received (appendix 1)
- Clear reasons for referral are identified by the referrer
- Patient's GP or consultant agrees with the referral
- Patient has a progressive life-limiting disease

Plus one or more of the following:

- Patient has complex physical, psychosocial, emotional and/or spiritual problems
- Patient shows a progressive decline and increasing frailty
- There is a need for specialist advice to other health care professionals (HCP) regarding continuing palliative care treatment plans
- Patients referred to community or outpatient services should primarily reside in the given catchment areas of south side of Glasgow, East Renfrewshire or Cambuslang and Rutherglen

- Patients with a non-malignant diagnosis referred to any service should have where possible a disease specific CNS to optimize the appropriate care requested

Short term symptom management support may be available for some patients with potentially curative disease.

Complex issues affecting access to Hospice services should be discussed with the Consultant or senior member of the medical/nursing team

All patients who meet the criteria will be considered irrespective of disease, age, disability, gender, ethnic group, religious beliefs and sexual orientation (Equality Act 2010).

Access to Hospice services is in accordance with the QIS Standards for Specialist Palliative Care.

4.2 Referral pathway

4.2(a) Who can refer:

Referrals are accepted from Consultants or GPs. Referrals are also accepted from any health care professional with the consent of the patient's GP or Hospital Consultant. The referrals may originate from primary care, acute care, care homes or other tertiary sites (e.g. other hospices, private hospitals/homes).

Patients (or their guardian), may self-refer to Hospice services. Appropriate supporting information about a patient's condition will be required from relevant health care professionals.

4.2(b) How to refer:

- During office hours a hospice referral form (appendix 1) can be obtained by phoning 0141 429 9823 or downloaded from the hospice website **(www.ppwh.org.uk)**. Referral forms are available in all GP practices and hospital sites.
- Completed referral forms can be submitted in the following ways
    - SCI Gateway system
    - Secure email from *nhs.net* email accounts
    - Referrals should be sent from NHS.net accounts: GG-UHB.PPWHClinicalAdmin@nhs.net
    - Fax using a secure line
        - Hospice fax number is **0141-429-8406**
    - Post
        - All referrals sent by post must be marked 'Private and Confidential' and be sent to a designated clinician
- Only urgent referrals may be made by telephone by those referrers with immediate access to patient records. These calls will be referred to medical staff for a decision and must be followed up with a completed referral form.
- All referrals should be accompanied by relevant and recent clinical information on diagnosis, stage of illness, treatments and medication, current care and family issues. In the case of an incomplete referral form more information will be sought by a member of the multidisciplinary team before the referral is accepted.
- On occasion, there will be individuals who have palliative care needs but do not fit all the relevant criteria. In these situations, it is encouraged to discuss the

patient directly with the Hospice team by phone and if appropriate, an assessment visit by a palliative care specialist will be offered.

4.2(c) Referral review/decision:
All new referrals are discussed at the daily multidisciplinary referral meetings (Monday to Friday). Initially patient's needs are assessed using the information on the referral form and acceptance to hospice services is prioritised accordingly.

Urgent requests for admission to the in-patient unit will be considered 24 hours a day, 7 days a week out with the daily referral meeting. Such requests should be discussed with the Hospice duty doctor.

On acceptance, referrals are assigned to the requested palliative care service, or may be redirected to another more appropriate service after discussion between the team and the referrer.

4.2(d) Contact with referrer/patient:
If a patient is referred to community or outpatient services, a letter is sent to the referrer within 2 working days to confirm receipt of the referral. The letter will inform the referrer of the outcome e.g. acceptance, waiting list, declined (appendix 2).

If the patient is referred to the in-patient unit, telephone contact is made with the referrer within 24 hours to confirm receipt of referral, confirming the outcome eg acceptance, waiting list, declined.

Where there is a delay in referrer contact the reason for the delay is recorded in accordance with NHS QIS standard 1.a.11.

4.2(e) Contact with the referred patient:

If a patient is accepted to community or outpatient services, the relevant Hospice service will make initial contact with the patient by telephone to arrange a first meeting. However, if the patient is required to go on a waiting list, the patient will be informed by letter which will provide named contact details of a hospice clinician whom they can contact should their circumstances change (appendix 3).

If a hospital patient is accepted to the in-patient unit (or put on a waiting list), the referrer, usually a hospital clinician, will inform the patient. If a patient is in the community, the hospice team will liaise with the referrer and often the patient directly to organise admission/inform them that they are on a waiting list.

4.2(f) Adherence with referral policy
Adherence to the referral policy is recorded using a combination of the Hospice referral adherence form (appendix 4) and the Referral management template within the electronic patient record system (appendix 5).

4.3: Inpatient services
The inpatient unit seeks to meet the needs of patients with a life-limiting illness through a multidisciplinary team of specialists in palliative care. Inpatient care is most appropriate for patients with complex multidimensional needs which cannot be resolved in other care settings. All requests for beds are prioritised in relation to the individual level of need as assessed by the appropriate health care professionals (community team, hospital palliative care team, GP, district nurse).

4.3 (a) Criteria for admission to inpatient unit

- Patient has distressing physical, psychosocial, emotional or spiritual symptoms which are difficult to manage in their current place of care.
- Patient has an acute decline secondary to non-malignant diseases and has either decided to discontinue active treatment, or is willing to accept the limitations of active management available in the Hospice setting.
- Patient requires a period of inpatient specialist assessment for effective symptom management or crisis intervention that cannot be given or delivered in their current place of care.
- Patient may benefit from a period of specialist assessment and rehabilitation to maximise active functional potential to return home (e.g. after an aggressive palliative chemotherapy regime or spinal cord compression).
- Patient is at the end of life (i.e. estimated prognosis of less than 2 weeks) and is either unable to be cared for appropriately elsewhere or their preferred place of care is in the hospice.

Admission to hospital should be considered for any patient who develops an acute or unexpected problem that would benefit from further investigation and treatment.

Patients in hospital should be assessed by the hospital palliative care team before referral if possible, but if not, referrals can be discussed with the on call doctor at the Hospice for individual consideration.

4.4 Community specialist palliative care team

The community team consists of specialist medical and nursing staff who are supported by the extended multidisciplinary team in the hospice. They provide a 7 day service between the hours of 9am-5pm which is delivered by home visits, telephone advice and review in the hospice. This service has a capacity level and if this is reached a waiting list may be necessary and patients prioritised based on need.

The team also provides specialist palliative care information, advice and support to the primary health care team (particularly GPs and District Nurses) who are the key managers of the patients' medical and nursing care in the community. Where possible, joint home visits with relevant member(s) of the primary health care team should be arranged at key points in the patients care for advanced care planning (e.g. place of care, end of life care).

4.4 (a) Criteria for access to the community service

- Patient requires a period of specialist assessment for effective symptom management, complex advance care planning, psychosocial, emotional or spiritual support
- Patient has an acute decline secondary to non-malignant diseases and has decided to discontinue active treatment and be cared for in their own home
- Patient may benefit from a period of specialist assessment and rehabilitation to maximise active functional potential to maintain care at home.
- Patient is at the end of life (i.e. estimated prognosis of less than 2 weeks) and has indicated their preferred place of care is in the home.
- Patient's relatives and carers require advice and support

4.5 Outpatient services

The hospice offers a wide range of outpatient services with the aim of promoting independent living and optimising quality of life for as long as possible. We recognise that one size does not fit all and our model of care provides an individualised and patient centered approach which can be tailored to patient choice and identified need. Regular assessment and collaboration with other health care professionals allows for the provision of a flexible service which can respond to changes in a patient's health or circumstances.

The following outpatient services are available:

- **Day services**
  - Day Services combines both a traditional model of hospice day care and a therapeutic programme-based model of care. Most patients attend one or other of these services, but some patients may attend both
  - **Traditional model**
    - Open to referred patients (maximum of 20 places per day) three days a week (Mon, Wed, Thurs) from 10am-3pm
    - Offers specialist assessment and input from the Hospice multidisciplinary team as well as a variety of activities, companionship and peer support
  - **Programme-based services**
    - If deemed appropriate, programme-based services may be offered to patients attending both traditional model day services and outpatient clinics.
    - Programmes are usually appointment based, time limited and can be one-to-one or group sessions. Programmes can be delivered in the Hospice or in a patient's own home
    - Programmes may include :
      - Let's Be Active (breathlessness management)
      - Relaxed Lives (anxiety management)
      - Complementary therapy
      - Art/Creative Writing
      - Disease specific programmes e.g. COPD courses
      - Drop-in programmes covering various topics e.g. dealing with breathlessness, money worries.

  Patients referred to Day Services are invited to attend for an initial assessment. Following assessment, a plan of care will be agreed where specific goals and objectives are set. Progress will be reviewed at regular intervals (usually every 8 or 12 weeks). If goals and objectives have been met, or if there are changes in a patient's condition that means they can no longer attend Day Services, discharge and possible transfer to another Hospice service will be considered.

- **Palliative care outpatient clinics**
  - Symptom management clinic
    - Medical clinic runs weekly
    - Nurse led clinic runs throughout the week
  - Therapeutic intervention clinic

- Enables patients to undergo investigation e.g. abdominal ultrasound or to receive interventional treatments e.g. blood transfusions or bisphosphonate infusions
- Scheduled according to patient need

4.5 (a) Criteria for access to day services

- Patient requires a period of specialist assessment for effective symptom management and/or psychosocial, emotional or spiritual support.
- Patient requires assistance to improve function/quality of life when there is a progressive decline and increasing frailty
- Patient should primarily reside in the given catchment areas of south side of Glasgow, East Renfrewshire or Cambuslang and Rutherglen.
- Patient is able to attend Day Services by their own transport, volunteer's car or hospice transport. If volunteer or hospice transport is required, patient should be able to manage domestic stairs (internal or external) with minimal assistance from a volunteer driver or hospice staff.

4.5 (b) Criteria for access to palliative care outpatient clinics

- Patient requires a period of specialist assessment for effective symptom management and/or psychosocial, emotional or spiritual support
- Patient requires specialist assessment of complex symptomatology
- Patient has potentially curative disease but requires short term symptom management
- Patient requires assistance to improve function/quality of life when there is a progressive decline and increasing frailty
- Patient requires therapeutic intervention (e.g. bisphosphonate infusion/paracentesis) to optimise symptom management
- Patient is able to attend Clinic by either their own transport or volunteer's car. If volunteer transport is required, patient should be able to manage domestic stairs (internal or external) with minimal assistance.

Compliance with Policy

Referral adherence will be audited bi-annually by clinical governance coordinator (or nominated other).

Reasons for referrals to hospice services will be monitored by the clinical admin team and clinical governance team on an annual basis.

Clinical activity will be monitored by the clinical leads, hospice clinical governance committee and the hospice board on an ongoing basis.

6. References

1. Audit Scotland, 2008. *Review of Palliative Care Services in Scotland.* Edinburgh

2. Clinical Standards Board for Scotland (NHS QIS). June 2002*. Clinical Standards: Specialist Palliative Care.* Edinburgh:

3. Cochrane, E. Colville, E. Conway, R. 2008. Addressing the needs of patients with advanced non-malignant disease in a hospice day care setting. *International Journal of Palliative Nursing Vol.14 (8) pp.382-387.*

4. GGNHS. 2006 Service *Agreement for Hospice Providers.*

5. Gold Standards Framework Scotland website
http://www.gsfs.scot.nhs.uk/

6. NHS Forth Valley Palliative Care Manual. 2006 (reviewed 2008)

7.NHS QIS 2005 National Standards Clinical Governance and Risk Management, Edinburgh

8.. Scottish Executive. Sept. 2005 *National Care Standards; Hospice Care*

9. Scottish Government. 2007 *Better Health Better Care*

10. Scottish Government. 2008 *Living and Dying Well: a national action plan for palliative and end of life care in Scotland.*

11. Scottish Parliament. *Adults with Incapacity (Scotland) Act 2000.* Edinburgh: HMSO

12. Scottish Partnership for Specialist Palliative Care (SPPC). 2008*. Living and Dying with Advanced Heart failure: a palliative approach.* Edinburgh

12. NHS MEL (1997) 45. *Guidance on the use of facsimile transmissions for the transfer of personal health information within the NHS in Scotland*

7. Appendices

Appendix 1: Hospice referral form
Appendix 2: Referrer contact letter
Appendix 3: Patient contact letter
Appendix 4: Hospice referral adherence form
Appendix 5: Crosscare referral management template

Appendix 1

Prince & Princess of Wales Hospice
71 Carlton Place, Glasgow G5 9TD
Medical fax (secure line): 0141 429 8406
Tel: 0141 429 9823 Website: www.ppwh.org.uk
Secure email (from nhs.net accounts): GG-UHB.PPWHClinicalAdmin@nhs.net

Word 2003 Users: If the radio buttons on this form are unresponsive, please follow these steps: go to the Tools menu, click Macro and then Security. Set your security level to Medium then click OK. Now close and re-open the form. At the prompt, click Enable Macros.

REFERRAL FOR						
Community Palliative Care:	Hospice Community Team	☐				
Outpatient Services:	Day Services	☐	Outpatient Medical Clinic	☐	Nurse-led Clinic	☐
Inpatient Admission:	Symptom Control	☐	End of Life Care	☐	Assessment	☐
For more information about what each service offers, please refer to our website						

REFERRED BY			
Name:		Contact number:	
Designation:		Date:	

PATIENT DETAILS			
Surname:		DoB:	
Forename:		CHI:	
Address:		Postcode:	
		Tel. No.:	
Religion:		Marital status:	Please select from menu
Ethnicity:	Please select from menu	Is patient aware that referral is being made?	◉ Yes ○ No
Current location of patient:	◉ Home ○ Hospital ○ Nursing Home ○ Other		

IF REFERRING FROM HOSPITAL			
Hospital:		Ward:	
Consultant:		Tel. No.:	

NEXT OF KIN DETAILS			
Surname:		Address:	
Forename:			
Relationship to patient:		Postcode:	
Tel. No.:		Aware of referral:	○ Yes ◉ No

IMPORTANT - Completed referral forms should be submitted via secure nhs.net email to GG-UHB.PPWHClinicalAdmin@nhs.net

GP DETAILS			
Name:		Address:	
Tel No.:			
Postcode:			
Aware of referral:	○ Yes ◉ No		

SOCIAL SUPPORT					
Lives with:				DN in attendance?	○ Yes ◉ No
DN Name:				DN Tel No:	
Care Package?	○ Yes ◉ No	Details:			

MEDICAL INFORMATION					
Diagnosis:				Date of Diagnosis:	
Metastatic Disease:					
Treatment to date (surgery, chemotherapy, radiotherapy etc.):					
Patient's understanding of disease & prognosis:					
Mobility:				Housebound?	○ Yes ◉ No
Personal care:		Continence:			
Past medical history:					
Current medication:					
Allergies:				Pacemaker?	○ Yes ◉ No

IMPORTANT - Completed referral forms should be submitted via secure nhs.net email to GG-UHB.PPWHClinicalAdmin@nhs.net

CURRENT ISSUES			
Please choose the severity of the following from 0 to 4; 1 being none and 4 being overwhelming			
Agitation	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	Spiritual/existential distress	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4
Nausea/vomiting	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	Patient distress/anxiety	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4
Dyspnoea	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	Family distress/anxiety	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4
Constipation	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	Confusion	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4
Ascites	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	Depression	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4
Distress due to care environment	(•) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4	End of life care (last 48 to 72 hours of life)	( ) Yes (•) No
Other (please specify)			

Pain (please give numerical scale rating)	No pain	(•) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10	Severe Pain

ADDITIONAL INFORMATION

IMPORTANT - Completed referral forms should be submitted via secure nhs.net email to GG-UHB.PPWHClinicalAdmin@nhs.net

Appendix 2

Our Ref: JH/

Dr «GP_NAME»
«GP_ADDRESS1»

26 August 2014

Dear Dr

Re: «PATIENT_FIRSTFORENAME» «PATIENT_SURNAME», («DATE_OF_BIRTH»), «PATIENT_ADDRESS»

The above patient has been referred to the Prince & Princess of Wales Hospice by «Referrer», «Referrer_source» and we would like to acknowledge that the referral has been accepted by «Care_Team» Palliative Care Team.

We would be grateful if you could include the Hospice in any future correspondence involving this patient's care, including any relevant investigation results.

Please do not hesitate to contact the hospice at any time regarding future care.

Yours sincerely

Jackie Husband
Director of Clinical Services

Appendix 3

Our Ref:

«Title» «First_Forename» «Surname»
«Patient_Address»

26 August 2014

Dear «Title» «Surname»

The Prince and Princess of Wales Hospice has received a referral by «Referrer», «Referrer_source», for the Laurieston Community Palliative Care Team to support you at home.

You have been placed on a waiting list and I will be in contact as soon as the team is able to arrange to visit you. Your GP and district nurse have been made aware of this referral and can be contacted if you have any immediate problems.

If you have any questions or concerns, please do not hesitate to contact the hospice at any time regarding your care on 0141 429 5599.

Yours sincerely

«Carer_Name»
Laurieston Palliative Care Nurse

Appendix 4

The Prince & Princess of Wales Hospice

REFERRAL ADHERENCE FORM

Referral Demographics

Patient Details: Name:

Postcode:

Hospice number: CHI number:

Date referred:

Date referral received by hospice:

Date referral discussed by MDT:

Referrer Details: Name:

Designation:

Service Requested: Community Services:

- ☐ Day Services
- ☐ Medical Out-patient Clinic
- ☐ Laurieston Team (CNS)
- ☐ Laurieston Team (medical)

In-Patient Unit: ☐ Ward admission

Patient aware/understands referral? ☐ Yes ☐ No

Primary Diagnosis:

ICD10 Code for diagnosis

MDT Discussion/Decision

Referral accepted: ☐ Yes ☐ No

Date referral accepted:

Reason for not accepting referral:

- ☐ Further details required for later discussion by MDT
- ☐ Inappropriate referral
- ☐ Out of area

Referral initially assigned to:

- ☐ Day Services
- ☐ In-Patient Unit
- ☐ Medical Out-patient Clinic
- ☐ Laurieston Team ☐ S.West ☐ S.East

Laurieston CNS: _____

Referral Management

Contact with referrer:

Receipt of referral confirmed:

Date: _____

Day of week: _____

By who? Name:

Designation: Clinical Admin

If out with 2 working days, why?

Decision on referral confirmed:

Date: _____

Day of week: _____

By who? Name:

Designation:

Contact with patient/carer:

Receipt of referral confirmed:
(ie. first contact with patient)

Date: _____

Day of week: _____

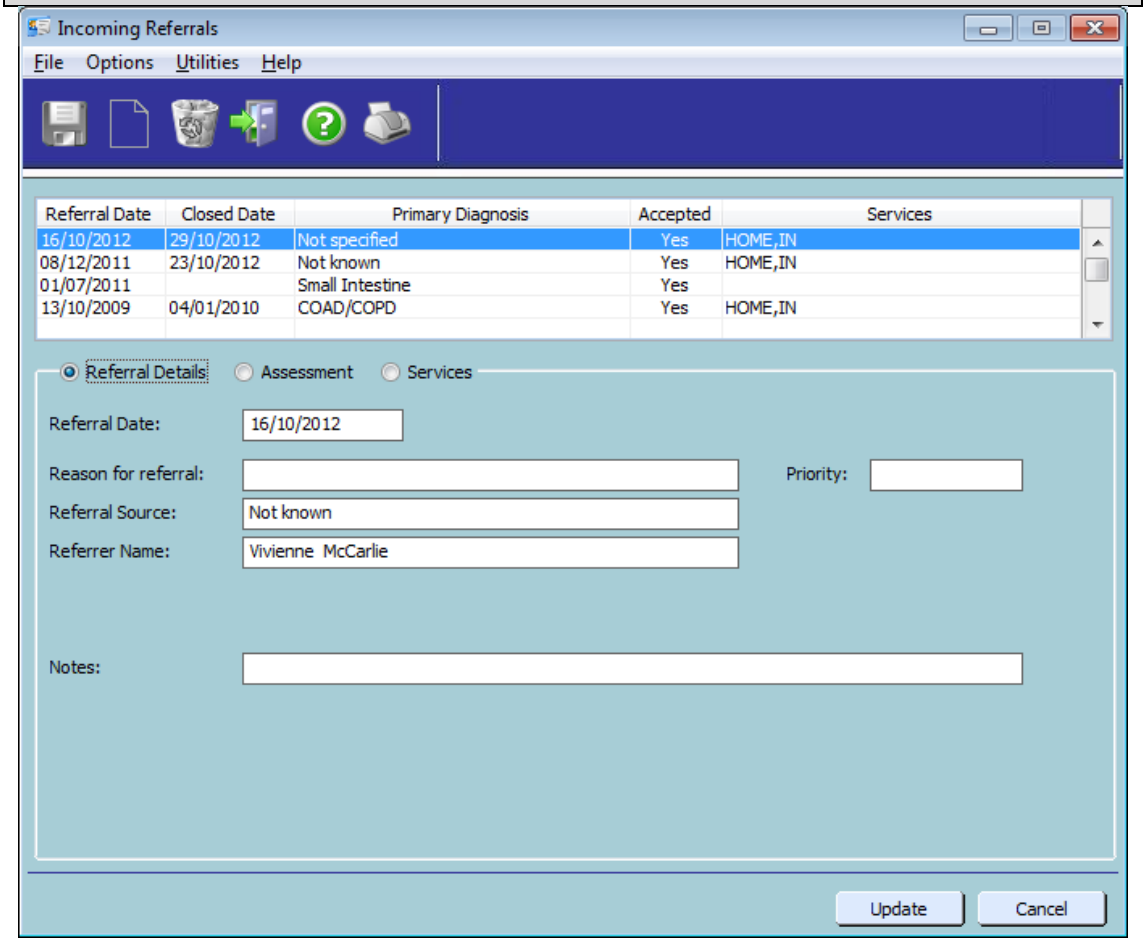
By who? Name:

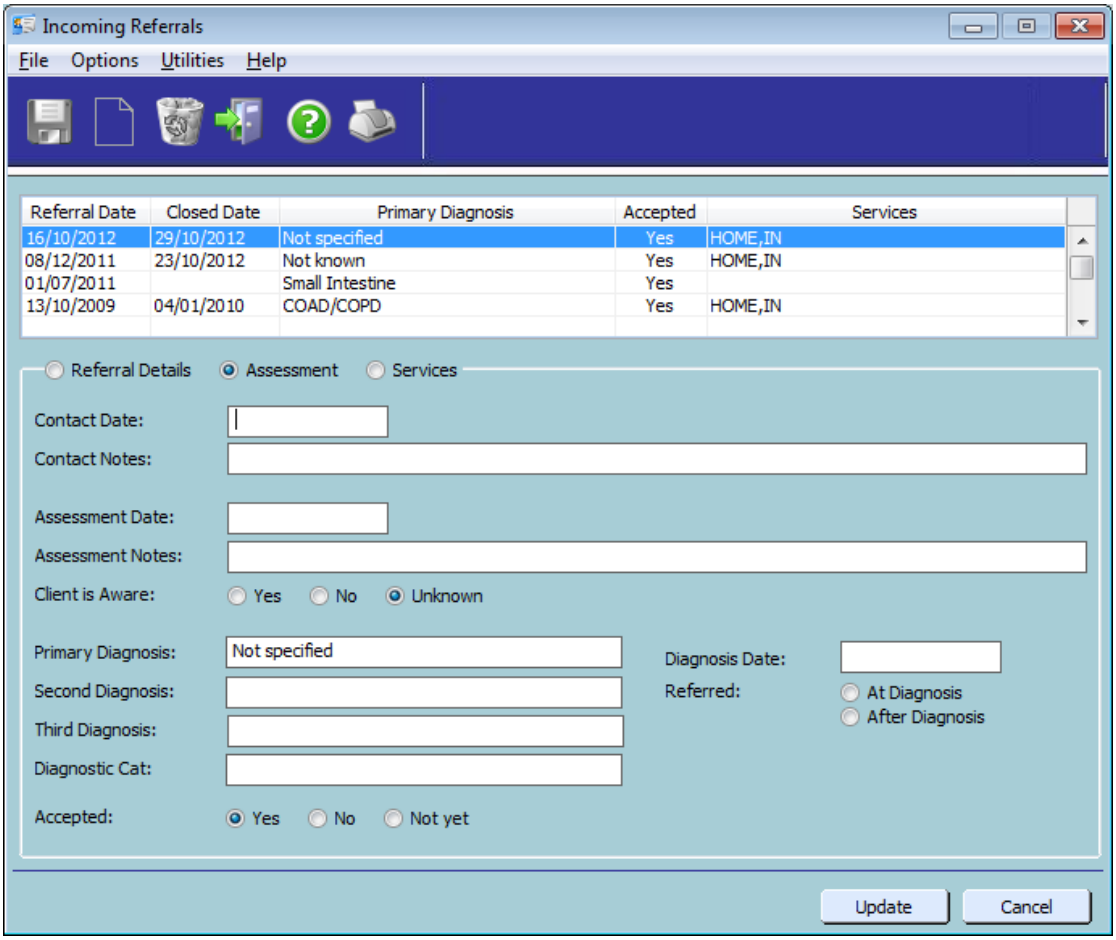
Designation:

Contacted via: ☐ Telephone ☐ Visit

If out with 2 working days, why?

Appendix 5


Incoming Referrals
File
Options
Utilities
Help
Referral Date
Closed Date
Primary Diagnosis
Accepted
Services
16/10/2012
29/10/2012
Not specified
Yes
HOME,IN
08/12/2011
23/10/2012
Not known
Yes
HOME,IN
01/07/2011
Small Intestine
Yes
13/10/2009
04/01/2010
COAD/COPD
Yes
HOME,IN
Referral Details
Assessment
Services
Referral Date:
16/10/2012
Reason for referral:
Priority:
Referral Source:
Not known
Referrer Name:
Vivienne McCarlie
Notes:
Update
Cancel


Incoming Referrals
File
Options
Utilities
Help
Referral Date
Closed Date
Primary Diagnosis
Accepted
Services
16/10/2012
29/10/2012
Not specified
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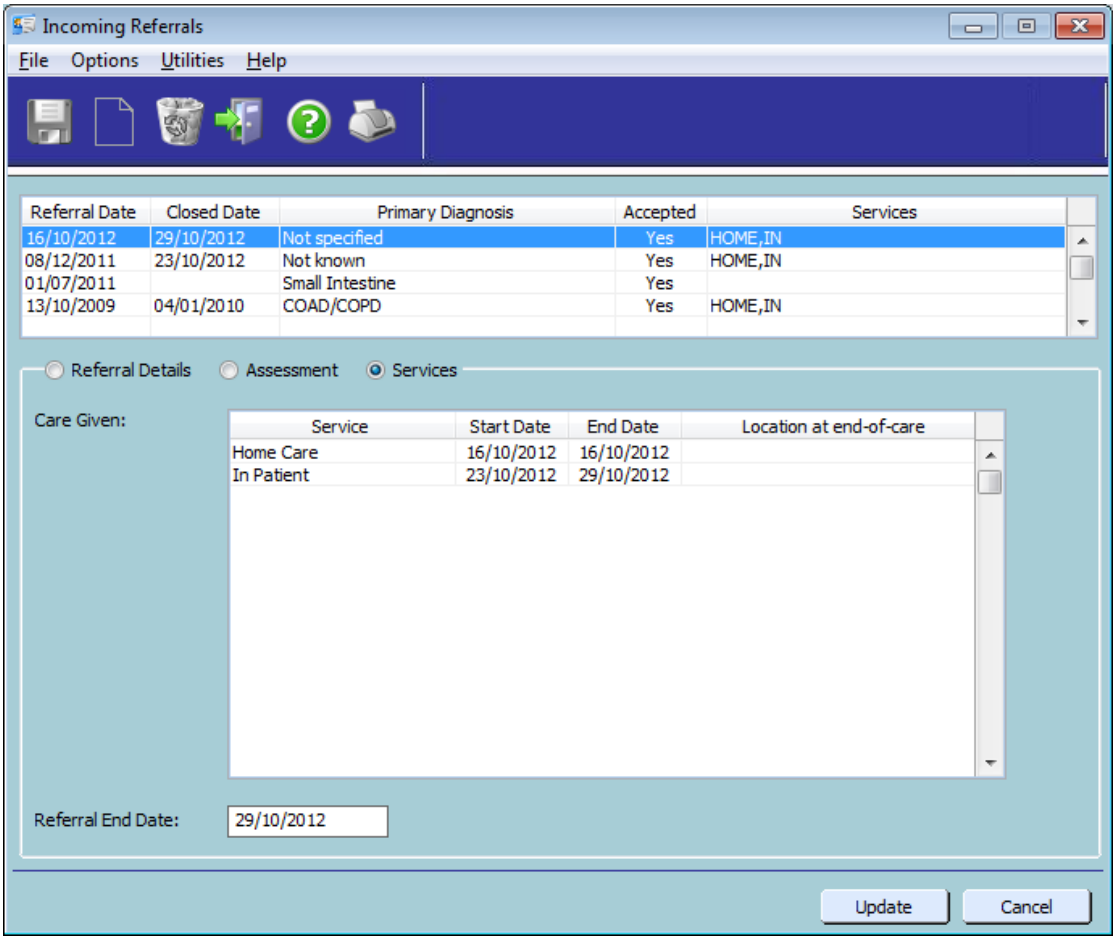
08/12/2011
23/10/2012
Not known
Yes
HOME,IN
01/07/2011
Small Intestine
Yes
13/10/2009
04/01/2010
COAD/COPD
Yes
HOME,IN
Referral Details
Assessment
Services
Contact Date:
Contact Notes:
Assessment Date:
Assessment Notes:
Client is Aware:
Yes
No
Unknown
Primary Diagnosis:
Not specified
Second Diagnosis:
Third Diagnosis:
Diagnostic Cat:
Diagnosis Date:
Referred:
At Diagnosis
After Diagnosis
Accepted:
Yes
No
Not yet
Update
Cancel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Services
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23/10/2012
Not known
Yes
HOME,IN
01/07/2011
Small Intestine
Yes
13/10/2009
04/01/2010
COAD/COPD
Yes
HOME,IN
Referral Details
Assessment
Services
Care Given:
Service
Start Date
End Date
Location at end-of-care
Home Care
16/10/2012
16/10/2012
In Patient
23/10/2012
29/10/2012
Referral End Date:
29/10/2012
Update
Cancel