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| Referral Form for a COMPASSIONATE COMPANION to support the patient and their loved ones to live fully whilst living with a life limiting condition. | |  |
| Patient Name: | Patient NHS No: | | |
| Patient Tel No:  Patient Mobile: | Patient Date of Birth: | | |
| Patient Address:  Email address: | Referrer name and Address:  Referrer Tel No: | | |
| Patient diagnosis: | Date of diagnosis: | | |
| Patient’s Next of Kin/carer if applicable: | Date of referral: | | |
| Next of kin/carer Tel No: | GP name and Address:  GP Tel number: | | |
| Does patient give permission for NOK to be contacted by the compassionate companion team? Yes  No  (Please click on relevant box for X to be inserted) |

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| Is the patient aware of the referral and happy for contact to be made by the compassionate companion team:  (Please click on relevant box for X to be inserted) Yes  No |
| **Are you aware of any advance planning in place (e.g. DNR status)?**  **If so, please document here:** |
| Expected prognosis: days  few months  more than 6 months   (Please click on relevant box for X to be inserted) |

REASON FOR REFERRAL:

**To provide non-medical and compassionate support to individuals in their last year of life and their loved ones.**

Support people to live their lives as fully as possible before they die.

Enable conversations about the choices available at the end of life and work alongside medical teams to inform them to be able to honour those choices.

Improve end of life care in our communities across Suffolk.

THIS REFERRAL IS TO BE EMAILED TO KATE BARBER at: [Kathryn.barber@esneft.nhs.uk](mailto:Kathryn.barber@esneft.nhs.uk)

who will contact the patient to arrange a visit and match to a companion.

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| Is there anything else we need to know e.g. notable conversations: |

**PLEASE NOTE:** Not all referrals will result in a Compassionate Companion being allocated as it is availability dependant. **Please advise the patient of this.**

*For Use by the Compassionate Companion Team only*

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| Date of proposed visit: |
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| Consent for compassionate companion gained: Yes  No |
| Name of Compassionate Companion allocated: |

Notes:

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Name of visiting clinician: ………………………………………………

Signed……………………………………… Date……………………….