EAST LANCASHIRE HOSPICE
HOSPICE AT HOME RISK ASSESMENT FORM

Telephone: 01254 733450 **Fax: 01254 665000**

Please complete the risk assessment form in addition to the generic referral form provided			
Surname: First Name:	M ☐ F ☐	NHS No: Religion:	Marital Status: Ethnic Group:
Next of Kin: Relationship: Name: Address: Tel. No: Mobile No: Can information regarding your care and condition be shared with this person? **Yes** ☐ **No** ☐			
District Named Nurse: Base: Tel No: Fax No: Mobile:			

	Yes	No	How will staff gain access to home?
Does the patient live alone?			
Is the patient aware of referral?			Keypad No:
Is family/carer aware of referral?			

Reason for Referral: Last Days of Life ☐ Complex Discharge ☐ Health care Support ☐
Social Support ☐ Carer Support ☐

Additional Questions	**Yes**	**No**
Is the patient aware of the diagnosis		
Is the patient aware of the prognosis		
Is the patient for resuscitation		
Is the patient a research participant (record study)		
Is there community documentation within the home to support care delivery, i.e. care plans		
Have any risks been identified within the home environment eg smoking, any pets etc. Details:		
Are Social Services involved Social Worker's Name: Base: Contact No:		
Is Marie Curie Involved Date of referral:		
Is any formal care provision in place Details:		
Is a Community Matron involved Name: Base: Contact No:		
Is a Clinical Nurse Specialist involved Name: Base: Contact No:		

Does the patient have any problems with:	Yes	No	Details
Pressure areas			
Pain			
Elimination			
Other Symptoms			
Wounds			
Risk of infection eg MRSA			
Hygiene			
Mobility (if yes is there equipment available in the home to manage this)			
Breathing			
Eating/drinking			
Medicine management			
Communication			
Emotional state			
Meeting social needs			

Details of facilities for staff within the home:

Toilet			
Heating			
Telephone access			
Is protective clothing available if applicable			
Is appropriate seating available for the carers shift			

Complete the section below and specify the most appropriate person to deliver the care

H.C.A. ☐

Hospice at Home will offer a maximum of 3 nights cover by a H.C.A. (availability permitting)
Please tick which 3 nights are preferred if known.

Start Date:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Volunteer Sitter ☐

Hospice at Home can offer 3 hour slots during the day.
Please tick which day is preferred if known.

Start Date:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
	am **pm**	**am** **pm**	**am** **pm**	**am** **pm**	**am** **pm**	**am** **pm**	**am** **pm**

Referrer Name: **Designation/Base:**

Contact Telephone No: **Date and time of referral:**