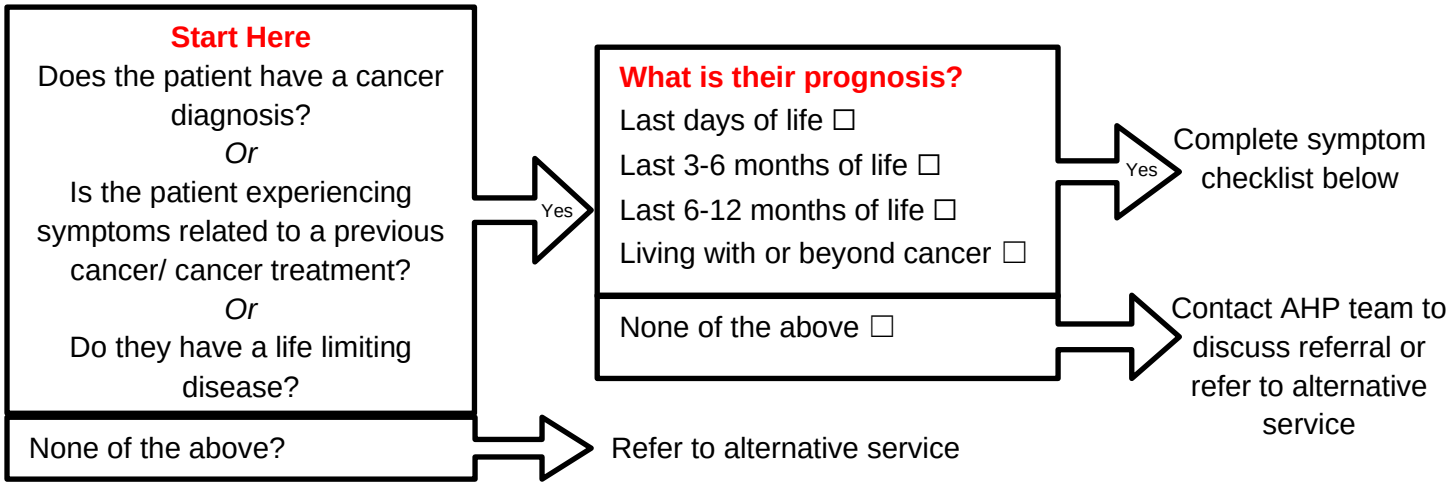
Macmillan Palliative Care & Complex Cancer AHP Team Referral Checklist & Referral Form

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

The **Macmillan Palliative Care and Complex Cancers AHP Team** is a multidisciplinary team, employed by WWL NHS Foundation Trust, comprising Physiotherapists, Occupational Therapists, a Dietitian and a Speech and Language Therapist. We see patients over the age of 18 who are experiencing difficulties as a result of their cancer, cancer treatment or life-limiting condition. Prior to referral, please ensure the patient has consented to being referred to the Macmillan Palliative Care and Complex Cancers AHP Team.



Patients must present with three or more of the below symptoms to require AHP team input. Symptoms should be due to their cancer diagnosis/ treatment or palliative condition. If not, please refer to alternative teams. If three symptoms are present, please complete referral form.

Bowel obstruction ☐
Difficulty adapting to decline in function ☐
Dysgeusia (taste change) ☐
Dysphagia (oral/pharyngeal) ☐
Psychological distress affecting function inc anxiety, body image ☐
Excessive secretions ☐
Fatigue ☐
Nausea ☐
Weight loss of over 10% of body weight ☐
Rapidly changing symptoms ☐
Normal occupational being/role affected by illness ☐
Pain ☐
Symptoms of pancreatic insufficiency ☐
Peripheral neuropathy ☐
Musculoskeletal impairment affecting function ☐
Mobility issues (ambulatory/ non-ambulatory) ☐
Severe shortness of breath affecting function ☐
Dysphasia/ dysarthria (language/speech difficulties) ☐

Current Location of Patient / Service User:

……..

Telephone Number(s):

Consent given to referral? **YES / NO** *(circle as appropriate)*

Informed consent given to share information with all agencies, as required to provide care? **YES / NO** *(circle as appropriate)*

If no, state with whom information must not be shared:
……

Patient / Service User Details

Surname: …… Title: ……..

Forename: ……

Address: ……

……

Post Code: ……

DoB: …… Age: ……..

NHS Number :

Gender:

Known Allergies:

Religion:

Ethnicity:

Language:

Interpreter Required? **YES / NO** *(circle as appropriate)*

Current or past occupation: *(please indicate if current/ retired service personnel)*

…… ……

Patient Name.....

NHS Number.....

Key Contacts	Name	Address	Contact No.
Next of Kin			
General Practitioner		*If not a Wigan GP, they must have a Wigan Council address*	
Referrer			

Lives alone? YES / NO *(circle as appropriate)* If no, lives with .....

Accommodation, specify type: eg. house, bungalow, etc. .....

Owner occupied / rented Nursing Home / Residential Home / Sheltered Accommodation

Access and any risk issues identified? YES / NO *(please detail in final box below)*

History of present condition and medical diagnosis

Present Consultant: **Consultant Base:**

Relevant Past Medical History	**Preferred place of care**

REASON FOR REFERRAL
(please provide as much information as possible to enable prompt processing of referral)

Please indicate assessment required

Occupational Therapy ☐ Physiotherapy ☐ Acupuncture ☐

Speech and Language Therapy ☐ Dietitian ☐ Fatigue management ☐

Previous therapy intervention and client's response:
(e.g food fortification advice, existing equipment in place)

Client's goals for this referral:

Please send to: Macmillan AHP Team Tel: 01942 525566 macmillan.ahpteam@nhs.net

Signed.....Date:.....Role:.....

Please ensure the above is completed in full. Any incomplete referrals will not be accepted and will be returned to the referrer. *Please do not use abbreviations*.