TRANSMISSION VERIFICATION REPORT

TIME : 29/09/2010 16:00
NAME :
FAX :
TEL :

DATE, TIME	29/09 15:59
FAX NO. /NAME	902083669810
DURATION	00:01:13
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

THE NORTH LONDON PALLIATIVE AND SUPPORTIVE CARE NETWORK

Referral Form

(Please Tick)

- ☐ **Barnet Community – See North London Hospice**
- ☐ **Barnet Hospital Macmillan Palliative Care Support Team**
  Tel: 020 8216 4446
  Fax: 020 8216 4409
- ☐ **Chase Farm Hospital Macmillan Palliative Care Support team**
  Tel: 020 8375-2384
  Fax: 020 8375-1070
- **Camden PCT and UCLH Palliative Care Team**
  - ☐ Hospital Support Team
  - ☐ Community
  Tel: 020 7380 6811
  Fax: 020 7380 6812
- ☑ **Enfield Community Palliative Care Team**
  Tel: 020 8367 4099
  Fax: 020 8366 9810
- ☐ **Haringey Macmillan Palliative Care Team**
  Tel: 020 8442 5544
  Fax: 020 8442 6288
- ☐ **Harley Street Clinic, Palliative Care Team**
  Tel: 020 7935 7700 Bleep 54
  Fax: 020 7486 2887
- ☐ **Islington *EHPSe* (End of Life & Palliative Care Service) Team**
  Tel: 020 7690 3567/8
  Fax: 020 7690 3576
- ☐ **Marie Curie Hospice Hampstead**
  Day Therapy Unit / Outpatient Unit
  Tel: 020 7853 3430/29
  - ☐ Fax 020 7853 3438
  Inpatient Unit
  Tel 020 7853 3400
  Fax 020 7853 3437
- **The North London Hospice:**
  - ☐ Inpatient Unit
  - ☐ Community Team
  - ☐ Day Care
  Tel: 020 8343 8841
  Fax:020 8343 7672
- ☐ **The North Middlesex Hospital Palliative Care Team**
  Tel: 020 8887 2475
  Fax: 020 8887 4237
- **The Royal Free Hospital Palliative Care Support Team**
  - ☐ Hospital Support Team
  - ☐ Community
  Tel: 020 7830 2905
  Fax: 020 7830 2045
- **St Johns Hospice ***
  - ☐ In patient
  - ☐ Hospice at Home
  - ☐ Community
  - ☐ Day Care
  Tel : 020 7806 4040
  Fax: 020 7806 4041
- **St Josephs Hospice***
  - ☐ In Patient
  - ☐ Community team
  - ☐ Day Care
  Tel: 020 8525 6084
  Fax 020 8525 6085
- **West Essex Macmillan Palliative Care Team**
  - ☐ Hospital
  - ☐ Community
  Tel: 01279 694931
  Fax: 01279 694932
- **The Whittington Hospital Department of Oncology and Palliative Care:**
  - ☐ Hospital Support Team
  Tel: 020 7288 5227
  Fax: 020 7288 5788

* please note these services are not in the network but will accept referrals on this form

PATIENT DETAILS (in capitals please)

SURNAME CURTIS TITLE MR
FIRST NAME MATTHEW (MALE) / FEMALE
ADDRESS GRO-C
POSTCODE GRO-C
TEL GRO-C MOBILE
MARITAL STATUS SINGLE DOB Not Relevant AGE 37
NHS NUMBER (If Known) GRO-C

NEXT OF KIN / MAIN CARER

NAME ANNA CURTIS
RELATIONSHIP TO PT MOTHER
ADDRESS AS ABOVE
POSTCODE
TEL
MOBILE GRO-C

PRIMARY DIAGNOSIS Metastatic Carcinoma Dx 2010. IS PATIENT AWARE OF DIAGNOSIS (YES) / NO

PALLIATIVE CARE TEAM

NAME ....

BASED AT.......... ENFIELD

TEL.......... FAX..........

DISTRICT NURSE

NAME..........

BASED AT.......... ENFIELD

TEL.......... FAX..........

OTHER SERVICES / PROFESSIONALS / INFORMAL SUPPORT PATIENT RECEIVES AT HOME (please indicate contact numbers and frequency of visits where known)

DN referral will be done.

HISTORY OF ILLNESS AND TREATMENT and PAST MEDICAL HISTORY (please enclose copies of relevant medical letters, blood results and investigation results)

~~See attached sheet~~

HAEMOPHILIA, HIV+ GASTRIC CA c METS, PERITONEAL DISEASE, (L) CEPHALIC FISTULA.

CURRENT PROBLEMS

Haemophilia A CONSTIPATION.

HIV.

PR bleed.

Dysphagia, epigastric pain

HAS CPR BEEN DISCUSSED WITH THE PATIENT? (YES) / NO IF YES: CPR Status .... DNAR

ALLERGIES.......... NKDA

Oxygen requirements YES / (NO)
if yes:details..........

MRSA (or other Hospital Acquired Infection)

MEDICATION

NAME OF DRUG	DOSE	FREQUENCY	NAME OF DRUG	DOSE	FREQUENCY
FLUCONAZOLE	100mg	OD	ATORVASTATIN	20mg	OD
~~See attached~~		~~sheet~~	ENSURE	1	QDS.
TRANEXAMIC ACID	1g IV	QDS.	TRUVADA	1	OD
DOMPERIDONE	20mg	TDS	RALTEGRAVIR	400mg	BD
OMEPRAZOLE	20mg	OD	MST	10mg	BD

WHERE IS THE PATIENT AT PRESENT *(PLEASE TICK)*

○ AT HOME

✓ IN HOSPITAL.......... RFH .... WARD.......... 11 WEST

○ ELSEWHERE (e.g. nursing home)..........

TEL NO.......... DISCHARGE DATE..........

NAME OF PATIENT.......... MATTHEW CURTIS DATE OF BIRTH.......... NOT RELEVANT

GRO-C '71

THE NORTH LONDON PALLIATIVE *AND* SUPPORTIVE CARE NETWORK
Referral Form

The North London Cancer Network

(Please Tick)

☐ **Barnet Community – See North London Hospice**

☐ **Barnet Hospital Macmillan Palliative Care Support Team**
Tel: 020 8216 4446
Fax: 020 8216 4409

☐ **Chase Farm Hospital Macmillan Palliative Care Support team**
Tel: 020 8375-2384
Fax: 020 8375-1070

Camden PCT and UCLH Palliative Care Team
☐ Hospital Support Team
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Tel: 020 7380 6811
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☐ **Islington *EliPSe* (End of Life & Palliative Care Service) Team**
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Fax: 020 7690 3576

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Tel 020 7853 3400
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☐ Community Team
Day Care
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Fax:020 8343 7672

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Fax: 020 8887 4237

The Royal Free Hospital Palliative Care
☐ Support Team
☐ Hospital Support Team
Community
Tel: 020 7830 2905
Fax: 020 7830 2045

St Johns Hospice *
☐ In patient
☐ Hospice at Home
☐ Community
☐ Day Care
Tel : 020 7806 4040
Fax: 020 7806 4041

St Josephs Hospice*
☐ In Patient
☐ Community team
☐ Day Care
Tel: 020 8525 6084
Fax 020 8525 6085

West Essex Macmillan Palliative Care Team
☐ Hospital
☐ Community
Tel: 01279 694931
Fax: 01279 694932

The Whittington Hospital Department of Oncology and Palliative Care:
☐ Hospital Support Team
Tel: 020 7288 5227
Fax: 020 7288 5788

* please note these services are not in the network but will accept referrals on this form

PATIENT DETAILS (in capitals please)

SURNAME: CURTIS TITLE: MR

FIRST NAME: MATTHEW (MALE) / FEMALE

ADDRESS: GRO-C

GRO-C POSTCODE: GRO-C

TEL: GRO-C MOBILE:

MARITAL STATUS: SINGLE DOB: NOT RELEVANT AGE: 37

NHS NUMBER (If Known): GRO-C

NEXT OF KIN / MAIN CARER

NAME: ANNA CURTIS

RELATIONSHIP TO PT: MOTHER

ADDRESS: AS ABOVE

POSTCODE:

TEL:

MOBILE: GRO-C

PRIMARY DIAGNOSIS: Metastatic Carcinoma DX 2010 : IS PATIENT AWARE OF DIAGNOSIS (YES) / NO

DATE OF DIAGNOSIS: July 2016 IS PATIENT AWARE OF REFERRAL (YES) / NO

GP DETAILS

NAME: VINCENT

ADDRESS: CARLTON HSE SURGERY

28, TERMS TOWN RD.

POSTCODE: EN2 1JL TEL: 020 8363 7575

PCT: FAX:

IS GP OR CONSULTANT AWARE OF REFERRAL YES / NO

HOSPITAL DETAILS

HOSPITAL: RFH

CONSULTANT: MISHER

TEL: GRO-C HOSPITAL NO: GRO-C

HOSPITAL:

CONSULTANT:

TEL: HOSPITAL NO:

REFERRED BY: R ALLEN

TITLE: WARD SISTER DATE OF REFERRAL: 28/9/16

CONTACT DETAILS: X GRO-C

REFERRED FOR:
Community Support Team/ Inpatient / Outpatient / Day Care / Hospice at Home *(Delete)*

☑ SYMPTOM CONTROL ☑ CONTINUING CARE
☐ RESPITE ☐ REHABILITATION

SOCIAL, CULTURAL AND SPIRITUAL ISSUES (please include who the patient lives with and details of children under 18)

LANGUAGE SPOKEN ENGLISH

INTERPRETER REQUIRED YES (NO)

DETAILS OF ANY RISK FACTORS FOR STAFF WHEN CARING FOR THIS PATIENT

NONE

ANY ADDITIONAL INFORMATION

REFERRING PT FOR SYMPTOM CONTROL, PAIN CURRENTLY MANAGED WELL, C/O CONSTIPATION @ PRESENT. WILL REQUIRE SUPPORT @ HOME ALSO, PT LIVES IC MUM.

THANK YOU.

FOR OFFICE USE ONLY

Please fax or send completed referral form to the appropriate team. If Faxing please send on hard copy when possible
Please ensure that you send enclose copies of relevant medical letters, blood results and investigation results
Unfortunately if the form is not fully completed this may delay response.

NAME OF PATIENT..... MATTHEWS ..... CHRIS DATE OF BIRTH.... GRO-C 1971

Re-Faxed 05/10/2010

TRANSMISSION VERIFICATION REPORT

TIME : 29/09/2010 14:29
NAME :
FAX :
TEL :

DATE,TIME	29/09 14:29
FAX NO./NAME	902083422145
DURATION	00:00:26
PAGE(S)	01
RESULT	OK
MODE	STANDARD ECM

Provider Services

Fax to: ~~020 7530 4654~~

Camden NHS
Primary Care Trust

Referral Form for the Adult Community Nursing Service

District Nursing Service Management Team ☐ | Tissue Viability (including wound clinic) ☑ | Community Matron ☐ | Chronic Disease ☐

Please tick the service you require

Disease Management Area of Patient: Desmond ☐ Dermatology ☐ COPD ☐

Please type the referral form or complete in BLOCK CAPITALS in black ink

Referral made by: R. SHAOAT **Occupation:** SN **Address:** RFH **Tel No:** GRO-C **Fax No:**	**Name:** ROSIE SHAOAT **Signature:** GRO-C	**Date of referral:** 29/9/10 **Planned Discharge Date:** 30/9/10.

Patient Details:

Mr. ☑ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ..... **Ethnic Origin:** WHITE ENGLISH

Surname: CURTIS **First Name:** MATTHEW.

DOB: GRO-C 71 **Age:** 37 men. **NHS Number:** GRO-C

Address: GRO-C

Postcode: GRO-C **Tel:** GRO-C

Next of Kin: ANNA CURTIS **Relationship to patient:** MOTHER.

Address: S/A

Postcode: **Tel:** GRO-C

GP Practice: CARLTON HOUSE SURGERY **GP Name:** DR. VINCENT

Practice Address: TENNISWOOD ROAD
ENFIELD 08 444 770129

Postcode: EN2 **Tel:** [redacted] **Fax:**

Reasons for referral AT LEWISHAM HOSPITAL BED + ARE MATTRESS

TRANSMISSION VERIFICATION REPORT

TIME : 29/09/2010 16:13
NAME :
FAX :
TEL :

DATE,TIME	29/09 16:13
FAX NO./NAME	902083422145
DURATION	00:00:20
PAGE(S)	01
RESULT	OK
MODE	STANDARD ECM

Provider Services Fax to ~~020 7330 1654~~ Camden NHS Primary Care Trust

Referral Form for the Adult Community Nursing Service

District Nursing Service ☑ Tissue Viability (including wound clinic) ☐ Chronic Disease
Management Team ☐ Community Matron ☐ Please tick the service you require

Disease Management Area of Patient: Desmond ☐ Dermatology ☐ COPD ☐

Please type the referral form or complete in BLOCK CAPITALS in black ink

Referral made by: R. SHADAT **Occupation:** SW **Address:** RFH EXT **Tel No:** GRO-C **Fax No:**	**Name:** ROSIE SHADAT **Signature:** GRO-C	**Date of referral:** 29/9/10 **Planned Discharge Date:** 30/9/10.

Patient Details:
Mr ☑ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ..... **Ethnic Origin:** WHITE ENGLISH

Surname: CURTIS **First Name:** MATTHEW.

DOB: NOT RELEVANT **Age:** 37 **NHS Number:** GRO-C

Address: GRO-C

Postcode: GRO-C **Tel:** GRO-C

Next of Kin: ANNA CURTIS **Relationship to patient:** MOTHER.

Address: S/A

Postcode: **Tel:** GRO-C

GP Practice: CARLTON HOUSE SURGERY **GP Name:** DR. VINCENT

Practice Address: TENNISWOOD ROAD
ENFIELD
08 444 770929

Postcode: EN2 **Tel:** ~~[redacted]~~ **Fax:**

Reasons for referral PT REQUIRES HOSPITAL BED + AIR MATTRESS

Refaxed 05/10/2010

Provider Services

Fax to ~~020 7530 4654~~

Camden NHS
Primary Care Trust

Referral Form for the Adult Community Nursing Service

District Nursing Service ☐ Tissue Viability (including wound clinic) ☑ Chronic Disease Management Team ☐ Community Matron ☐ Please tick the service you require

Disease Management Area of Patient: Desmond ☐ Dermatology ☐ COPD ☐

Please type the referral form or complete in BLOCK CAPITALS in black ink

Referral made by: R SHROAT **Occupation:** SN **Address:** RFH **Tel No:** GRO-C **Fax No:**	**Name:** ROSIE SHROAT **Signature:** GRO-C	**Date of referral:** 29/9/10 **Planned Discharge Date:** 30/9/10.

Discharged: 05/10/10

Patient Details:
Mr ☑ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ..... **Ethnic Origin:** WHITE, ENGLISH

Surname: CURTIS **First Name:** MATTHEW.

DOB: NOT RELEVANT **Age:** 37 men. **NHS Number:** GRO-C

Address: GRO-C

Postcode: GRO-C **Tel:** GRO-C

Next of Kin: ANNA CURTIS **Relationship to patient:** MOTHER.

Address: S/A

Postcode: **Tel:** GRO-C

GP Practice: CARLTON HOUSE SURGERY **GP Name:** DR. VINCENT

Practice Address: TENNISWOOD ROAD
ENFIELD
08 444 770929

Postcode: EN2 **Tel:** ~~[illegible]~~ **Fax:**

Reasons for referral PT REQUIRES HOSPITAL BED + AIR MATTRESS ASAP PLEASE AS PT IS UNDER TO DETERIORATE. Please also order viral bottle + bed pan.

Relevant Past Medical History: CA STOMACH RC METS, HIV+, MACRENIA, HAEMAPHILIA, ⓔ EPIPHANIC FISTULA.

Problems: PR BLEED, WOUND C FRAME / STICC, CONSTIPATION

Drugs: MST long, ABREVIATION, TRAMADOL, RALTEGRAVIR 400mg, TRANEXAMIC ACID 1gm, OMEPRAZOLE 20mg, FLUCONAZOLE 150mg.

Allergie NKDA.

PLEASE NOTE THAT ALL REFERRALS SHOULD BE FAXED TO ~~020 8919 8519~~ ONLY.
REFERRALS SENT TO OTHER NUMBERS WILL NO LONGER BE ACCEPTED.
THE SCREENING PHONE LINE IS 020 7530 4655.

ROYAL FREE HAMPSTEAD NHS TRUST

COMMUNICATION SHEET

Hospital Number: GRO-C	Surname: Curtis	First Names: matthew

Date & Time	EACH ENTRY MUST BE SIGNED / PLEASE ALSO PRINT YOUR NAME.
29/9/10	> obs stable, febrile but no BCIs taken
	> bloods taken from fistula.
	> No IVI.
	> IV Tranexamic acid ☑
	> c/o constipation, sodium docusate ☑
	> plan dlc
	> DNR reg ☑ for hospital bed + oral matters
	> Comm PT ☑
	> PT ☑
	> Sat in chair, walked c frame to toilet
	> all care given
	> monitor cannula site
	> MST given
	> Pt refused Sec 2, says mum will manage. Mum is happy returning Sec 2.
	> no other issues today. GRO-C
	> Transport booked for tomorrow @ 1500 - but may need cancelling if pt unit going (H).
	> TTAIS ☐ GRO-C
30/9/10	> Pt appeared to sleep well overnight.
0600	> No c/o any pain or discomfort.
	> IV tranexemic acid given
	> All other p.r.n meds given + taken
	> All needs met overnight.
	> No new changes to report GRO-C
0730	> Temp ↑ 38.5°C Dr informed + will come to culture GRO-C

RF956

continued overleaf

GRO-C

Date & Time	EACH ENTRY MUST BE SIGNED / PLEASE ALSO PRINT YOUR NAME.
29/9/10	> paracetamol given.
	> Dr r/v'd no cultures needed as already done on 29/9/10.
	po Augmentin commenced — GRO-C S/N.
30/9/10	MOT.
1530	Home — needs hospital bed mattress chase D/N referral.? Mother will do p. care at present they have refused SS —
30/9/10 1345	> Obs stable
	> Abx meds given
	> Po Tranexamic acid given
	> Spoken with DN Jane (GRO-C) re: bed + mattress etc, I informed her that it was urgent + she said she will do an urgent form + will get back to me later to confirm.
	> Mum aware that she needs to clear space for bed delivery.
	> TTA's D
	> No transport required, will (H) earlier tomorrow late afternoon or sat morning
	> pt self caring c. ADLs today
Mo aware	> a/w team + Dr. Mayer to speak with family this afternoon D
	> Comm PCT have received referral DT
	> no complaints voiced — GRO-
	> Community Equipment Service : 0208 279 6959 Ring this number asap re: wrap bed will be delivered — GRO-C
	> d/w team nurse to ensure they speak to haematology team re: nurse to go to pts (H) to give injection D — GRO-C

GRO-C

Date & Time	EACH ENTRY MUST BE SIGNED / PLEASE ALSO PRINT YOUR NAME.
30/9/10	> paracetamol given.
	> Dr r/v'd no cultures needed as already done on 29/9/10.
	PO Augmentin commenced — GRO-C S/N.
30/9/10	MDT.
1230	Home — needs hospital bed, mattress chase D/N. referral.? Mother will do p. care at present they have refused SS —
30/9/10 1345	> DBS Starde
	> Abx meds given
	> PO Tramadol acid given
	> Spoken with DN Jane (GRO-C) re: bed + mattress etc, I informed her that it was urgent + she said she will do an urgent form + will get back to me later to confirm.
	> Mum aware that she needs to clear space for bed delivery.
	> TTAIS D
	> No transport required, am (H) earlier tomorrow late afternoon or sat morning
	> pt self caring c ADLS today
Mo aware	> a/w team + Dr. Mayer to speak with family this afternoon D
	> Comm PCT have received referral DT
	> ni complaints voiced — GRO-C
	> Community Equipment Servce : 0208 379 6959 P ring this number more re: when bed will be delivered — GRO-C
	> d/w team nurse to ensure they speak to haematology team re: nurse to go to AIS (H) to give injection D — GRO-C

NHS London

Care Plan for Fast Track Patients

Inter-agency multi-disciplinary care plan for palliative care provision & placement. For an individual with a primary health need arising from a rapidly deteriorating condition which may be entering a terminal phase, with an increasing level of dependency.

This care plan is for use with the national fast track pathway tool, for patients who have been referred to the PCT for Continuing Healthcare funding to enable their needs to be urgently met (e.g. to allow them to go home to die or to allow appropriate end-of-life support to be put in place).

Patient registered with GP in: (insert name of PCT)	
Name: MATTHEW CURTIS	DOB: GRO-C 71 Age: 39 (Male)/Female
Home Address: GRO-C Telephone No: GRO-C	Name & Address of next of kin/contact: ANNA CURTIS GRO-C Telephone No: GRO-C Relationship: MOTHER
First Language: ENGLISH	Religion/cultural needs: Athiest
GP: DR P. VINCENT Address: 28 TENNISWOOD ROAD ENFIELD Tel No: 020844 477 0929 Fax No:	District Nurses Name: Louise Address: Tel: No: GRO-C Fax No:
Palliative Care Team: Louisa Price	Name of social worker/care manager Tel No:
Consultants Name: DR Prentice Mayer (Oncologist) DR Thomas McKelvey (Haematology) Consultant's Tel No:	Patients Current Location: Royal Free Hospital 4 South
Home Situation: Mother is assisted by the district nurse at home with Enteral feeds.	Social & Family Circumstances: Carer Input/Caring Network: Mother to Matthew stays with him at home with some help from the relatives.
Has the patient been involved in setting up and agreeing to this care plan? (Yes)/No *If not explain why:*	
Has the main carer been involved in setting up and agreeing to this care plan? (Yes)/No *If not explain why:*	

ROYAL FREE HAMPSTEAD NHS TRUST

COMMUNICATION SHEET GRO-C

Hospital Number: GRO-C	Surname: curtis	First Names: matthew

Date & Time	EACH ENTRY MUST BE SIGNED / PLEASE ALSO PRINT YOUR NAME.
30/9/10	> All px'd meds given + taken
2300	> Vital signs as charted
	> No pain or discomfort expressed.
	> Night sedation given prn — GRO-C
01/10/10	> No new changes overnight
0740	All needs met pm.
	No pain or discomfort expressed. GRO-C
01/10/10	– Pt observations stable [illegible].
07:45	– Due meds given as charted
	– Assisted with personal hygiene by night nurses.
	– Eating + drinking ok.
	– Seen by D – (P) – Home tomorrow.
	– TTA's D
	– own transport
	– Remove Canula D
	Pt mum reports to have received bed-side table,
	bath rail + commode but still waiting for bed
	to be delivered. I phoned CES on number
	provided ~~[illegible] closed~~ ~~[illegible]~~
	the bed should be delivered by 7PM, if not, office
	closed all weekend. Pt + Mum informed. GRO-C
Nocte	> Obs stable
	> All meds given
	> TTA script D / send home D
	> ring bed company home to chase delivery D
	> If bed delivered tomorrow then pt can
	go (H), no transport required.
	> Pt self caring is [illegible] → D

RF956

continued overleaf

NHS London

Name of Patient:	MATTHEW CURTIS

Does the patient, relative, friend or advocate have a preference on which nursing home placement & why?
If patient is to be cared for at home. Please complete pages 5 & 6

Primary & Secondary Diagnosis & other Medical Conditions

		Is the Patient Aware of Diagnosis? (Y)/N
(Primary) 1	Haemophelia	
(Secondary) 2	HIV +	If not why Not?
(Other) 3	Metastatic ca. stomach and dysphagia	

Pain:

Does the patient have unremitting and overwhelming pain despite all efforts to control pain effectively?				(Yes)/No	
	Absent	Mild	Moderate	Severe	Uncontrollable
Pain				✓	

Patient's current symptoms, aside from pain, which require regular (weekly) review *(please tick boxes)*

	Absent	Mild	Moderate	Severe	Uncontrollable
Nausea	✓		✓		
Dyspnoea/ Difficulty Breathing	✓				

Bleeding	✓			
Cough		✓		
Fatigue			✓	✓
Drowsy			✓	
Jaundice	✓			
Ascites	✓			
Confusion	✓			
Anxiety	✓		✓	
Depression	✓			
Insomnia				✓
Oedema	✓			
Other Retching				✓

Please describe specialist nursing needs and current symptom management:
(To be completed by CNS)

Matthew is significantly deteriorating – unable to take anything orally and NJ tube dislodged and so now on nil nutrition at present. Retching and pain ongoingly problematic requiring ↑ dose of opiate and antiemetic. Prognosis will further deteriorate and likely measured in terms of short to long weeks.

Date & Time	EACH ENTRY MUST BE SIGNED / PLEASE ALSO PRINT YOUR NAME.
	is booked for 10am + they will dispense
	them quicker than inpatient pharmacy
	>copy of d/c summary given to
	Mrs. Curtis. GRO-C
Nocte ->	Slept well during the shift
->	Observations stable, Had his due
5/10	Medications
7am ->	Home today. Please call [illegible]
	clinic if they can Dispense his
	Anti Viral Drugs – GRO-C
05/10/10	Patient remains cardiovascularly stable.
16.00	Clinical observation remains stable.
	~~Patient reports~~ no complaints of nausea
	or vomiting. TTA drug given to patient
	and explained. Appropriate information
	given to patient. Patient discharged
	home. Escorted by hospital transport
	District nurses referral refaxed. GRO-C

NHS London

Name of Patient: Matthew Curtis

Which of the following members will be involved in the care provision:

Occupational Therapist	(Y/N	Palliative Care Nurse	(Y/N	Hospital Doctor	Y/N
Physiotherapist	Y/N	Palliative Care Doctor	Y/N	Social Worker	(Y/N
District Nurse	(Y/N	Speech & Language	Y/N	GP	(Y/N
Other:					

Does the patient have drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition?	Yes (No)

Current Medication:

Medication	Dose	Frequency	Route	Duration
Zopiclone	7.5mg	Nocte	N.G. tube	daily
Movicol	two sachets	Twice daily	N.G tube	daily
Lansoprazole	30mg	once day	N.G tube	daily
Sodium Docusate	100mg	Twice daily	N.G. tube	daily
~~Augmentin liquid~~				
Raltegravir	400mg	Twice daily	N.G. tube	daily
Truvada	one	Nocte	N.G tube	daily
Nystatin	1ml	QDS	oral	daily
Morphine Sulphate	60mg	2mg/hour	Syringe driver	daily
Fluconazole	100mg	once daily	N.G tube	daily
Levomepromazine	6.25mg	2mg/hour		daily

Medication Review completed by: [redacted] Date: 19/11/10

Signature/ Designation: [redacted] CNS Palliative Care

GRO-C

Which multi disciplinary team members have been involved in the assessment for this patient? *(Please tick)*

☑ Occupational Therapist	☑ Palliative Care Nurse	☑ Hospital Doctor
☑ Physiotherapist	☐ Palliative Care Doctor	☐ Social Worker / Care Manager
☐ District Nurse	☐ Speech & Language	☐ GP
☑ Other: Haemophilia nurse		

NHS London

Name of Patient:	Matthew Curtis

Please describe general nursing needs (including moving & handling, equipment required, continence etc. Waterlow score, site & grade of any sores to be included)

No pressure sore. Needs a urinal and bedpans at home.

Current Functional Ability re: Personal Activities of Daily Living:

Patient is not for resuscitation and bed bound.
Needs help with dash / personal care.

Current Functional Ability re: Domestic Activities of Daily Living:

Not applicable
Mother carries out all household & domestic activities.

Current Mobility Level:

Unable to walk - bedbound due to ↑ fatigue, weakness and muscle wasting.

Current Mental Health:

Patient fully conscious and speaks sensible. However, withdrawn, anxious due to realisation of poor prognosis

Does the patient have an unstable condition?	(Yes)/No
Does the patient have a rapidly deteriorating condition?	(Yes)/No
Does the patient require a high level of specialist palliative care input?	(Yes)/No

NHS London

Matthew Curtis

Name of Patient:

Recommendations for Future Care
To be completed after discussion with patient, relative, friend or advocate:

Home	Nursing Home	Residential Home	Hospice
(Please indicate if care is to be provided at different address to that stated on page 1)			

Plans for review

Matthew and mother likely to need carers up to 4 times daily and possible night time support. Very anxious and in need of psychological support. Weekly + 2 weekly reviews by specialist palliative care nurse will be required.

(Patients requiring Continuing Care fully funded by the NHS or Continuing health & social care giving rise to both Social Services & NHS responsibilities will be reviewed regularly (at least every 3 months) by the specialist palliative care team involved or if no team is involved by the GP & District Nurse)

Assessment Confirmed by (Palliative Care Specialist/Consultant)

Name: Denise Ostalowski	Agency: RFH
Signature: GRO-C	Telephone No: GRO-C
Title/Profession: CNS Palliative Care	Date: 19/11/10

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To be completed if the patient is to be cared for at home

Name of Patient: Matthew Curtis

What services will be needed to enable patient to return home? (please tick/delete when appropriate)

☑ Home Care	☐ Physiotherapist	☑ ~~Day Hospital~~/Hospice
☐ Meals on wheels	☐ Day Care	☑ Respite Care
☑ District Nurse	☑ Twilight/ Night Service	☐ CPN
☑ Palliative Care Team	☐ Other Specialist Nurses (state specialty)	
☐ Other (Please Specify)		

Describe the proposed input of the above. Please be as detailed as possible giving frequency & duration of visits.

Patient on N.G feeds and needs to be monitored by the District nurse.
Requires a syringe driver for pain and retching.

Comments/ any other observations, entry to property (e.g. keys with neighbour)
Attach OT assessment as appropriate

NAME: CECILIA MLUNGU

TITLE: Staff nurse

SIGNATURE: GRO-C

DATE: 17/11/10