# Template Homecare Service Patient Change Request Form

## Introduction & Scope

The templateHomecare Service Patient Change Request Form is designed to help clarify and formalise communications between clinical referring centre and homecare provider when a change is needed for a registered patient for example when a patient needs to be put temporarily on-hold or their treatment permanently stopped.

The key aims are to:

* Provide a formal two-way record of communication of changes to a patient status with a prompt to necessary actions needed.
* Minimise the risk of not acted upon or lost messages leading to treatments being continued that should have been stopped
* Standardise the approach to this process across all clinical referring centre and homecare providers.

## Guidance notes and implementation

The relevant sections of this template are suitable for use without adaptation for most homecare medicines services. For complex or specialised services, the minimum level of adaptation necessary to meet the requirement should be undertaken.

## Template Form Page 1

The clinical referring centre can use the first page of the template form below as a single page form to inform the homecare provider that a change is needed for a patient.

Changes may be:-

* **Change in Service**. This, for example, could include saying that a patient no longer requires a nurse administration visit or asking for a nurse administration visit for a patient who has not previously required this element of the homecare service. Any changes in homecare service requested must be within the terms of the SLA relevant to that homecare service.
* **Put service on Hold.** This for example may be when a patient is in hospital or has failed to have the necessary blood monitoring performed. The on-hold review date is an indication for the homecare provider of when the service may be required to restart, however a “Restart” notice must be sent to reactivate the service for that patient.
* **Restart Service.** This is used to recommence the service for a patient previously on hold
* **Service Stop.** This is to inform the homecare provider that a patient no longer requires the service. There is a space to record the reason for the stop. The patient may have died or changed therapy. Completion of this informs the homecare provider of the background so that they can handle situations such as subsequent return of equipment or waste in a sensitive manner.

Page one of the form prompts the clinical referring centre to ensure that they have discussed the service change with the patient. For example told a patient that they have been put on hold and why, so that the patient does not request inappropriate deliveries.

## Template Form Page 2

Is optional but recommended for use by the clinical referring centre to ensure robust administration and record keeping. It prompts the clinical referring centre to check whether they need to attach a new/ revised prescription, purchase order to match the communicated change and to check whether the change requested is within the terms of the SLA. When the form reaches the homecare provider there are additional sections to accept the request and sign for the necessary actions. They can then return a copy of the completed form to the clinical referring centre to demonstrate that the information has been received and acted upon.

## Template Form Page 3

Page 3 is for Homecare Provider use when they wish to inform the clinical referring centre that they are making a change to the service provided for a patient.

Changes may be:-

* **Change in Service**. This, for example, could include a patient requesting deliveries outside the normal delivery times or location zones. The homecare provider can highlight whether or not the requested change is within the terms of the SLA. If not charge may have to be agreed between the homecare provider and the referred
* **Put service on Hold.** This, for example, may be when a patient has failed to be in to accept a delivery in more than one occasion or cannot be contacted by the homecare provider
* **Restart Service.** This, for example, is used to notify that the homecare provider has been able to recommence the service for a patient previously on hold e.g. patient put on-hold because they cannot be contacted is contacted and communication issue is resolved.
* **Service Stop.** This is to inform the homecare provider that a patient no longer requires the service. There is a space to record the reason for the stop. It may be that the patient has requested that the homecare company no longer provide the service before communicating with the clinical referring centres’ clinicians or homecare team.

At the bottom of page 3 there is a space for the clinical referring centre to record that they have acted on this information. They can then return a copy of the completed form to the homecare provider to demonstrate that the information has been received and acted upon.

## Pre-population and editable fields / sections

Each Homecare Organisation should add their logo and address to the header of forms they use – this information is not provided anywhere else. Homecare organisations may wish to issue these forms, or a mildly adapted version thereof, with the Homecare Provider or Therapy Area sections pre-populated. They may also wish to add some contact numbers or instructions as to where and to whom in their organisation to fax/email/post the form.

## Proposal for standard reason codes

|  |  |
| --- | --- |
| On Hold reasons   * Pregnancy related * Expected/planned in medicine pathway * Unplanned or emergency hospital admission * Awaiting clinical assessment and/or test results * Clinical decision – adverse drug reaction * Clinical decision – trial withdrawal * Patient choice * Unclassified | Service Stop Reasons   * Transfer same therapy to different homecare provider * Changed supply route – purchasing authority driven * Changed supply route - patient not suitable for homecare or clinical decision * Changed supply route – patient choice * Changed homecare therapy – same homecare provider * Changed homecare therapy – different homecare provider * Clinical decision to stop homecare therapy * Patient deceased * Unclassified |

## Patient Change Request Form Template – Embedded Document

A copy of the Patient Change Request Form Template without the guidance notes are embedded below to avoid formatting issues when removing content from this document



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Template:Homecare Service Patient Change Request Form from Clinical Referring Centre***  ***including On Hold***  ***and Service Stop*** | | | | | | |
| **Homecare Provider:** | | |  | | **Therapy Area / Service Contract:** |  |
| PATIENT DETAILS | | | | | | |
| *(Address label can be affixed here – Ensure all [\*] fields are completed)* | | | | | | |
| Hospital Number: | | | |  | | |
| Title |  | Forename: | |  | | |
| Surname: | |  | | |
| Date of Birth: | | | |  | | |
| Address: | | | |  | | |
| Postcode: | | | |  | | |
| NHS Number: | | | |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CHANGE TYPE** | | | | | | | | | |
| **Put service on-hold**  ***All elements of services to temporarily stop*** | | Requested date service to temporarily cease: | |  | | Date “on-hold” request to be reviewed by clinical referring centre | | |  |
| Reason for “on-hold” | | Choose an item. | | | | | |
| **Restart service**  ***Following on-hold request*** | | Requested date service to restart: | |  | | Is there any change to service to be restarted?  *if yes give detail in comments* | | | Yes  No |
| **Service stop**  ***Patient will be removed permanently from service; to re-start a stopped patient they will need to be re-registered as a “new” patient*** | | | | | | Requested date service to permanently cease | | |  |
| Reason for “service stop” | | | Choose an item. |
| **Change in Service**  ***Note: Some elements of service to continue or additional elements of service to be added*** | | Details of Change:- | | | | | | | |
| **Comments** | | | | | | | | | |
| CHANGE REQUESTED BY | | | | | | | | | |
|  I have discussed the change in Homecare service with the above named patient and provided adequate information to allow provision of informed consent. | | | | | | | | | |
| Signature: |  | | Name:  *(please print)* | |  | | Date of Change Request: |  | |

**This Homecare Service Patient Change Form must be forwarded with a valid prescription (if needed) to the Hospital’s Pharmacy Department (Homecare Team) prior to transmission to the relevant Homecare Company.**

FOR PHARMACY DEPT OFFICE USE ONLY

Change request reference (e.g. Contract ref/patient hospital number/change request date):-

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Change request reference (e.g. Contract ref/patient hospital number/change request date):-

Homecare provider change request ref (if known):-

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| CHANGE REQUESTED APPROVED BY | | | | | | | | |
| Patient individual Care Plan (PICP) updated and attached *f yes give reference and/or date* | | | Yes  No | | PICP Ref: | | | |
| New/revised Prescription attached | | | | | | Yes  No | | |
| Change within SLA/Contract terms   *If No, additional costs may be incurred, if required, request costs from Homecare Provider before approval* | | | | | | Yes  No | | |
| New/revised Purchase Order attached | | | | | | Yes  No | | |
| Comments- | | | | | | | | |
| Signature: |  | Name:  *(please print)* | |  | | | Date |  |
| APPROVED CHANGE REQUSTED SENT TO HOMECARE PROVIDER BY | | | | | | | | |
| Signature: |  | Name:  *(please print)* | |  | | | Date& Time: |  |

FOR HOMECARE PROVIDER USE ONLY

Clinical Referring Centre Change request reference:-       Homecare Provider Change request reference:-

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| **CHANGE REQUEST ACCEPTED BY HOMECARE PROVIDER (HCP)** | | | | | | | | | | |
| Additional cost to Purchasing Authority outside contract / SLA *if yes give details* | | | | | | | Yes  No | | | |
| Comments:- | | | | | | | | | | |
| CHANGE IMPLENTATION DETAILS | | | | | | | | | | |
| **Temporary service  on-hold** | | Date of last service prior to temporarily cease: | |  | | Date “on-hold” to be reviewed by clinician | | |  | |
| **Restart service**  ***Following on-hold request*** | | Planned date service to restart: | |  | | | | | | |
| **Service stop**  ***Patient will be removed permanently from service; to re-start a stopped patient they will need to be re-registered as a “new” patient*** | | | | | | Date of last delivery/service | | |  | |
| Homecare Provider Signature: |  | | Name:  *(please print)* | |  | | | Date/ Time: | |  |

**Return copy of completed form to Clinical Referring Centre for inclusion in patient records to show the requested change has been planned and/or implemented.**

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| ***[Template]Homecare Service Patient Change Request Form from Homecare Provider***  ***including On Hold***  ***and Service Stop*** | | | | | | |
| Homecare Provider  Change request reference | | | |  | **Therapy Area / Service Contract:** |  |
| PATIENT DETAILS | | | | | | |
| *(Address label can be affixed here – Ensure all [\*] fields are completed)* | | | | | | |
| Hospital Number: | | |  | | | |
| Title |  | Forename: |  | | | |
| Surname: |  | | | |
| Date of Birth: | | |  | | | |
| Address: | | |  | | | |
| Postcode: | | |  | | | |
| NHS Number: | | |  | | | |

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| **CHANGE REQUST NOTIFICATION FROM HOMECARE PROVIDER (HCP)** | | | | | | | | | | | |
| Additional cost to Purchasing Authority outside contract / SLA *if yes give details in Comments* | | | | | | | Yes  No | | | | |
| Comments:- | | | | | | | | | | | |
| CHANGE IMPLENTATION DETAILS | | | | | | | | | | | |
| **Temporary service  on-hold** | | Date of last service prior to temporarily cease: | |  | | Date “on-hold” to be reviewed by clinician, if known | | | |  | |
| Reason for “on-hold” | | Choose an item. | | | | | | | |
| **Restart service**  ***Following on-hold request*** | | Planned date service to restart: | |  | | | | | | | |
| **Service stop**  ***Patient will be removed permanently from service; to re-start a stopped patient they will need to be re-registered as a “new” patient*** | | | | | | Date of last delivery/service | | |  | | |
| Reason for “service stop” | | | Choose an item. | | |
| **Change in Service**  ***Note: Some elements of service to continue*** | | Details of Change:- | | | | | | | | | |
| Homecare provider signature: |  | | Name:  *(please print)* | |  | | | Date/ Time: | | |  |

FOR PHARMACY DEPT OFFICE USE ONLY

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| --- | --- | --- | --- | --- | --- |
| **CHANGE REQUST CONFIRMATION BY CLINICAL REFERRING CENTRE** | | | | | |
| Comments:  Clinical Referring Centre Change request reference:- | | | | | |
| Signature: |  | Name:  *(please print)* |  | Date/ Time: |  |

**Return copy of completed form to homecare provider for inclusion in patient records to show the requested change has been confirmed by Clinical Referring Centre.**