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| **SPECIALIST PALLIATIVE CARE REFERRAL FORM** **(CONFIDENTIAL)** | |
| PATIENT DETAILS: NHS NO: Click here to enter NHS No. COCH NO: Click here to enter COCH No. | |
| SURNAME:Click here to enter surname. | PATIENT KNOWN AS:Click here to enter text. |
| FIRST NAME(S):Click here to enter first name. | DATE OF BIRTH:Click here to enter DOB. AGE:Click here to enter text. |
| ADDRESS: Click here to enter address.  POST CODE:Click here to enter Post Code.  CONTACT NUMBER: Click here to enter text. | **CURRENT LOCATION OF THE PATIENT**: Click here to enter current location of patient |
| GENDER: Click here to enter gender. |
| MARITAL STATUS: Click here to enter marital status. |
| PATIENT’S OCCUPATION:Click here to enter occupation. |
| RELIGION:Click here to enter Religion. |
| ETHNIC ORIGIN: Click here to enter ethnic origin. |
| IS AN INTERPRETER REQUIRED? Yes  No |
| IF YES, WHICH LANGUAGE? Click here to enter text. |
| IS THE PATIENT AWARE OF AND IN AGREEMENT WITH THE REFERRAL?  YES  NO | IS THE GP / CONSULTANT  AWARE OF THE REFERRAL?  YES  NO |

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| MAIN CARER:Click here to enter text.  RELATIONSHIP TO PATIENT: Click here to enter text.  ADDRESS: Click here to enter text.  CONTACT NUMBER: Click here to enter text. | NEXT OF KIN: (IF NOT MAIN CARER) Click here to enter text.  RELATIONSHIP TO PATIENT: Click here to enter text.  ADDRESS: Click here to enter text.  CONTACT NUMBER: Click here to enter text. |

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| GP NAME: Click here to enter text.  GP PRACTICE ADDRESS: Click here to enter text.  GP TEL NO: Click here to enter text. | CONSULTANTS` NAMES AND LOCATIONS:  Please detail Consultants name and locations here. |

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| **PLEASE INDICATE WHICH SERVICE IS REQUIRED AT PRESENT (PLEASE SELECT):**  **HOSPITAL  HOSPICE  COMMUNITY** |

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| **HOSPITAL REFERRAL:** CONSULTANT OUPATIENT APPOINTMENT  tel – 01244 366086 fax - 01244 366115 |

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| **HOSPICE REFERRAL:** |
| HOSPICE DAY CARE  tel - 01244 851091 fax - 01244 851108 |
| COMPLEMENTARY THERAPIES  ACUPUNCTURE |
| HOSPICE ADMISSION |
| MEDICAL OUTPATIENT APPOINTMENT |

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| **COMMUNITY REFERRAL: Preferred referral route by email** |
| CWP COMMUNITY MACMILLAN TEAM  Email: [cwp.communitypalliativecare@nhs.net](mailto:cwp.communitypalliativecare@nhs.net)  Tel - 01244 340631 Fax – 01244 344658 |
| CWP COMMUNITY PHYSIOTHERAPIST/OCCUPATIONAL THERAPIST  Email: [cwp.communitypalliativecare@nhs.net](mailto:cwp.communitypalliativecare@nhs.net) Tel – 01244 315923 Fax – 01244 344658 |

**PATIENT NAME D.O.B.**

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| Click here to enter patient name. | Click here to enter DOB |

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| **REFERRED FOR:** | SYMPTOM CONTROL | EMOTIONAL SUPPORT | CARER SUPPORT |
| FINANCIAL ADVICE | END OF LIFE CARE | OTHER |

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| DIAGNOSIS: Click here to enter diagnosis.  SITE OF METASTASES: (IF MALIGNANCY)  Click here to enter site of metastases.  DATE OF DIAGNOSIS: Click here to enter date of diagnosis. | PLACE OF DIAGNOSIS: Click here to enter place of diagnosis  METHOD OF DIAGNOSIS:Click here to enter text.  DS1500 COMPLETED: YES  NO |

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| **AWARENESS OF DIAGNOSIS:** | PATIENT | CARER |  |
| **ACCEPTANCE OF DIAGNOSIS:** | PATIENT | CARER |  |

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| **HAS THERE BEEN A DISCUSSION WITH THE PATIENT AND/OR CARER ABOUT PREFERENCES INCLUDING PLACE OF CARE? YES  NO**  *IF YES, PLEASE PROVIDE MORE INFORMATION IN THE SUMMARY BOX.* |

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| **SERVICES INVOLVED** | **NAME** | **TELEPHONE NO** | **AREA/CLINIC** |
| HOME CARE | Enter name here. | Enter Tel No | Enter area/clinic here. |
| MACMILLAN NURSE | Enter name here. | Enter Tel No | Enter area/clinic here. |
| DISTRICT NURSE | Enter name here. | Enter Tel No | Enter area/clinic here |
| SOCIAL WORKER | Enter name here. | Enter Tel No | Enter area/clinic here |
| THERAPY SERVICES | Enter name here. | Enter Tel No. | Enter area/clinic here. |
| CRISIS REABLEMENT TEAM | Enter name here | Enter Tel No | Enter area/clinic here |
| OTHER | Enter name hre. | Enter Tel No | Enter area/clinic here. |

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| CURRENT MEDICATION:  Click here to enter current medication. | ALLERGIES:  Click here to enter any known allergies |

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| SIGNIFICANT PAST MEDICAL HISTORY:  Detail here any significant past medical history |

**PATIENT NAME D.O.B.**

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| Click here to enter patient name. | Click here to enter DOB |

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|  | **DATE** | **PROCEDURE** | **CONSULTANT** | **HOSPITAL** |
| SURGERY | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
| Free text any further information:- | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| RADIOTHERAPY | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name. | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
| Free text any further information:- | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| CHEMOTHERAPY | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name. | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
| Free text any further information:- | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| HORMONE THERAPY | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name. | Click here to enter Hospital. |
|  | Click here to enter a date. | Click here to enter procedure. | Click here to enter Consultant name | Click here to enter Hospital. |
| Free text any further information:- | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**PATIENT NAME D.O.B.**

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| Click here to enter patient name. | Click here to enter DOB |

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| **SUMMARY OF MAIN CONCERNS / ADDITIONAL INFORMATION:**  Click here to enter summary of main concerns/additional information. |

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| **FORM COMPLETED BY:** Click here to enter name. **JOB TITLE** Click here to enter Job Title  **LOCATION** Click here to enter Location . **CONTACT TEL** Click here to enter contact Tel No.  **SIGNED:** Click here to enter text. **DATE** Click here to enter a date. |

PALLIATIVE CARE REFERRAL FORM

H:\FORMS New or updated from June 2014\REFERRAL FORM for Specialist Palliative Care\REFERRAL FORM INTEGRATED adapted 13.10.16 CURRENT FORM.docx