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| Name of referrer: | Contact details: |
| Click here to enter text. | Telephone / mobile: **Click here to enter text.** |
| Email address: **Click here to enter text.** |
| Designation of referrer: | **Date of referral:** |
| Choose an item. | **Click here to enter a date.** |
| Referral for: | **Service required:** |
| Choose an item. | Choose an item. |
| Referral agreed with: | **GP Name:** |
| Choose an item. | **Click here to enter text.** |
| GP Address: | **GP Telephone Number:** |
| Click here to enter text. | **Click here to enter text.** |

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| Patient details: | | | | | |
| Title: Choose an item. | Surname: **Click here to enter text.** | | | Forename: **Click here to enter text.** | |
| DOB: Click here to enter a date. | Age: **Click here to enter text.** | Gender(please check box):  Male:Female: | | | NHS No:  **Click here to enter text.** |
| Patient home address / residence: | | **Contact details:** | | | |
| Click here to enter text. | | Telephone: **Click here to enter text.** | | | |
| Mobile: **Click here to enter text.** | | | |
| **Diagnosis and Date of Diagnosis:** | | | |
| **Click here to enter text.** | | | |
| Does the patient live alone Yes  No | | Is the patient aware of their diagnosis?Yes  No | | | |
| Has the patient had surgery in the last 12 months: Yes  No | | | | | |
| If YES please indicate what operation was performed Click here to enter text. | | | Date when performed.  Click here to enter a date. | | |

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| **Essential information supporting care:** | | |
| Preferred place of care (Check box) Home  Hospice  Nursing Home  Hospital | | |
| Does the patient have Mental Capacity? (Check box) | Yes ☐ No ☐ | |
| If NO does this patient have a DOL in place? | Yes ☐ No ☐ | |
| **Is there any supplementary information directing the care of this patient?** | | |
| Are any of the following in place? (please check box) | **Advanced Decisions** | Yes ☐ No ☐ |
| If YES please comment.  Click here to enter text. | **Emergency Health Care Plan** | Yes ☐ No ☐ |
| **DNACPR** | Yes ☐ No ☐ |
| **Lasting Power of Attorney** | Yes ☐ No ☐ |
| **Court of Protection Order** | Yes ☐ No ☐ |
| **if you tick YES to any of the list you are required to provide copies of the documentation on acceptance of referral** | | |

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| Carer / Next of Kin details: | |
| Carer / Next of Kin and relationship:  Click here to enter text. | Is the Carer /NoK aware of the diagnosis? Yes  No |
| Carer / NoK Address if different from patients:  Click here to enter text. | Telephone / mobile: |
| **Click here to enter text.** |
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| **Reason for referral and specialist palliative care / symptom control needs and relevant social circumtances:** | | |
|  | | |
| **Additional information: Risks** | | |
| Is there a history of physical/verbal aggression/challenging behaviour? If YES towards whom? Check box. Family/Friends  Carer  Care staff  Others | | |
| Does the patient have a recent history of falls? Yes  No  If YES please indicate how many over last 12 months  Click here to enter text. | | |
| Does the patient have current pressure ulcer(s) Yes  No  If YES please indicate grades and location.  Click here to enter text. | | |
| Is the patient on Oxygen therapy? Yes ☐ No ☐ If YES are they a smoker? Yes  No  Click here to enter text. | | |
| Does the patient have a current infection? Yes  No  If YES how is this currently being treated?  Click here to enter text. | | |
| Current Medication: | | |
| Click here to enter text. | | |
| Referral accepted by:  Click here to enter text. | Designation:  Click here to enter text. | Date:Click here to enter a date. |

Referrals will be accepted by phone, email, fax or in person. Completed forms can be returned securely via email to [NECNE.StCuthbertsHospiceReferrals@nhs.net](mailto:NECNE.StCuthbertsHospiceReferrals@nhs.net)