|  |  |
| --- | --- |
| 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.** |

|  |
| --- |
| 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. |

|  |
| --- |
| **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** |

|  |
| --- |
| 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.** |
|
|

|  |
| --- |
| **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 monthsClick 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. |

**Completed forms to be returned securely via email to** **NECNE.StCuthbertsHospiceReferrals@nhs.net**