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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pendleside Hospice Referral Form**  **Email:** [**pendlesidehosp.referrals@nhs.net**](mailto:pendlesidehosp.referrals@nhs.net) **Telephone: 01282 440100**  Please complete as fully as possible to avoid delay in referral to the service | | | | | | | | |
| **Has the patient consented to this referral?** | | | | | | Yes 🞏 | No 🞏 | |
| **Has the patient consented to sharing healthcare information e.g EMIS Sharing** | | | | | | Yes 🞏 | No 🞏 | |
| Patient Name |  | | Date of Birth | |  | Age |  | |
| Address (incl. postcode) | | | Marital Status | |  | | | |
|  | | | Ethnicity | |  | | | |
| NHS Number | |  | | | |
| Current location of the patient | | | | | |
|  | | | | | |
| Does the patient live alone? | | | Yes 🞏 | | No 🞏 |
| Tel. Number |  | | Mobile Number | |  | | | |
| **Referral Priority 🞏 Urgent 🞏 Soon 🞏 Routine** | | | | | | | | |
| **Referral for (tick all that apply)** | | | | | | | | |
| **INPATIENTS**  🞏 Assessment  🞏 Symptom Control  🞏 Last Days of Life  🞏 Rehabilitation | **HOSPICE AT HOME**  🞏 Hospice at Home  🞏 Extended Service  (Last days of Life)  🞏 Penpals Volunteers | **DAY SERVICES**  🞏 Day Service  🞏 Complementary Therapy  🞏 Physiotherapy  🞏 Psychological Support  🞏 Drop In Clinic | | **MEDICAL**  🞏 Outpatient  🞏 Home Visit | | **FAMILY SUPPORT**  🞏 Counselling  🞏 Spiritual Care  🞏 Complementary Therapy | | |
| **Clinical Information** | | | | | | | | |
| Diagnosis (incl date) | | | COVID-19 test? | | | Yes 🞏 | | No 🞏 |
| * Date of COVID-19 test * Result | | |  | | |
| Site of Metastases: | | | COVID-19 Symptoms? Temp/Cough | | | Yes 🞏 | | No 🞏 |
| Allergies | |  | | | |
| Reason for Referral (including current situation and problems) | | | | | | | | |
|  | | | | | | | | |
| **Treatment (incl dates)** | | | **Relevant Past Medical History** | | | | | |
| Surgery: | | |  | | | | | |
| Chemotherapy: | | |
| Radiotherapy: | | |
| Hormone Treatment: | | |

|  |  |
| --- | --- |
| **Patient Name:** | |
| **Current Medication** |  |
|  |  |
| **Next of Kin (name and address)** | **Relationship to patient** |
|  |  |
| **Telephone no:** |
| **Mobile no:** |
| **Main Carer (if different to Next of Kin)** | **Relationship to patient** |
|  | **Telephone no:** |
| **Mobile no:** |
| **Patient's GP** | **Telephone no:** |
|  |  |
| **Patient's Consultant** | **Telephone no:** |
|  |  |
| **District Nurse** | **Telephone no:** |
|  |  |
| **Specialist Palliative Care CNS** | **Telephone no:** |
|  |  |
| **Social Worker** | **Telephone no:** |
|  |  |
| **Other** | **Telephone no:** |
|  |  |
| **Current support provided by professional(s)** |  |
|  |  |
| **Name of Referrer (Block Capitals)** | **Position** |
|  |  |
| **Telephone No:** | **Mobile No:** |
| **Signature:** | **Date:** |

**\*\*\*Please email completed referral form to:** [**Pendlesidehosp.referrals@nhs.net\*\*\***](mailto:Pendlesidehosp.referrals@nhs.net***)

**Referrals can be made over the phone, if you are unable to email form**