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| **Pendleside Hospice Referral Form****Email:** **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: |

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| **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\*\*\***

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