



Referral Form

Colne Road, Reedley, Burnley, BB10 2LW Tel: 01282 440100 Fax: 01282 440123

Please complete as fully as possible to avoid delay in referral to the service.

Before completing please confirm that:

The patient's consent to the referral has been obtained (please circle answer) Yes No

The patient has agreed to sharing of healthcare information (please circle answer) Yes No

Name Date of Birth Age

Address (incl. postcode) Marital Status

Ethnicity

NHS Number

Current location of patient:

Lives alone Yes No

Telephone number Mobile number

Diagnosis Date of Diagnosis

Site of Metastases Allergies

Referral Priority: Urgent Soon Routine

Referral for:

INPATIENTS

Assessment Symptom Control Rehabilitation Last days of life

HOSPICE at HOME

Hospice at Home Extended Service PenPals Volunteers

DAY SERVICES

Day Services Complementary Therapy Physiotherapy

Psychological Support Information & Resource Clinic (Drop In)

MEDICAL Medical Outpatients Clinic Medical Home Visit

FAMILY SUPPORT Counselling Spiritual Care Complementary Therapy

Reason for Referral (Including current situation and problems)

*Please enter N/A if any of the above questions are not applicable.

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:
Macmillan Nurse	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