

SPECIALIST PALLIATIVE CARE REFERRAL FORM – Initial information

Patient Details:

Name:		Tel No:	
DOB:		Occupation:	
Address:		Marital Status:	
NHS No:		Religion:	
Age:		Main Language:	
Smoker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is an Interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Bariatric	Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'Yes', please state weight in kgs:	

Main Carer / NOK:

Name:		Relationship to Patient:	
NOK? Yes <input type="checkbox"/> No <input type="checkbox"/>		Telephone:	
Can the patient speak over the Telephone to discuss referral if not who is best to call for further information if needed?			

Referrer Details:

Referrer Name:		Referrer Role	
Referrer Service:		Contact Email:	
Referral Date:		Contact Number:	
GP Name / Practice:			
<input type="checkbox"/> Patient aware of referral?		<input type="checkbox"/> GP aware of referral	

Reason for Referral:

<input type="checkbox"/> Symptom control	<input type="checkbox"/> Psychological/Spiritual	<input type="checkbox"/> End of life	<input type="checkbox"/> Other (specify):
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Refer to:

<input type="checkbox"/> Inpatient / Admission *Please fill in last section Inpatient / Admission Only	<input type="checkbox"/> Advanced Nurse Practitioner Clinic (Ambulatory Patients)	<input type="checkbox"/> Complementary Therapy (Service currently unavailable)	<input type="checkbox"/> Counselling
<input type="checkbox"/> Clinical Nurse Specialist		Note: All ambulatory patients will be offered clinic appointments as first line.	

SPECIALIST PALLIATIVE CARE REFERRAL FORM – Further information

Preferred Place of Care (Specify):		Any Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Place of Death (Specify):		
Advanced Decision to Refuse Treatment in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Resuscitation Status (Specify):		
Is a RESPECT FORM in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient want escalation for acute reversible causes? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Diagnosis and Past Medical History:

Main Palliative Diagnosis	Diagnosis'

Past Medical History:

Brief History of Events Leading to Current Problem:

What has been tried so far:

Current Medications:

Acutes	Repeats





Bassetlaw Hospice

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Registered Charity Number 701876

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Allergies & Sensitivities

Additional Relevant Information:



***SPECIALIST PALLIATIVE CARE REFERRAL FORM - Inpatient / Admission Only**

Cognitive Status: Any cognitive impairment, delirium, or confusion?	Communication Difficulties:

Mobility and Falls History:	Known Infections / Transmissible Diseases:

Skin Integrity:	Dietary / Nutritional Needs (e.g. swallowing difficulties, PEG):

Last Date of Radiotherapy or Chemotherapy:	Oxygen Therapy	
	Oxygen Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, how many litres:	

