Saint Michael's Referral Form

PLEASE RETURN TO HOSPICE MARKED "CONFIDENTIAL"
IF SYMPTOMS NEED URGENT MANAGEMENT, PLEASE TELEPHONE 01423 872658.

Please return to:
Saint Michael's Hospice
Crimple House, Hornbeam Park Avenue, Harrogate HG2 8QL
Nursing Services: Tel: 01423 872658 Fax: 01423 815454

REFERRAL TO:
☐ Inpatient Unit ☐ Day Therapy Unit ☐ Lymphoedema Clinic

Details of reason for referral

☐ Terminal Care ☐ Symptom Control
☐ Urgent Respite ☐ Assessment/Rehab

NOTE: The hospice operates a non-smoking policy within the building.

Patient Details:

Name:	NHS No:
Address:	Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
Telephone No:	Date of Birth:

Has patient consented to admission to hospice?
☐ Yes ☐ Yes

Details of person completing referral form:

Name:	Position held:
Address: Tel number:	
Date form completed:	Current whereabouts of the patient:

Professionals Currently Involved in Patient Care

General Practitioner:

Practice Address:

G.P. Telephone No:

Macmillan Nurse: Tel:	District Nurse: Tel:

Hospital Consultants:

Agreement of GP/Consultant for admission to hospice:
☐ Yes

Principal Carer:

Name:	Relationship to patient:
Address:	Telephone no:

Diagnosis:

Treatment History:

Other significant medical history:	Radiotherapy:
	Surgery:
	Chemotherapy:
	Other:

Patient's understanding of the diagnosis:

Current Major Symptoms/Reason for admission/Patient goals.

Medications:

Current Medications:

Previous medication for symptom control and reason for it being stopped:

Mobility

Level of mobility/aids to help with mobility.	Ease of access to patient's home: (Steps, lives in a flat etc.) Transport Issues – can they access a vehicle? ☐ Yes ☐ No

For Office Use Only:

Date Form Received..

Action: ....

☐ IPU ☐ DTU ☐ Lymph ☐ Wait List

Signature: ....