



Palliative Care Referral Form

**Referrals can be made electronically via SystemOne, by phone or fax
All urgent referrals should be made by phone**

<p>1. Palliative Care Team</p> <p>Hospital <input type="checkbox"/></p> <p>Community <input type="checkbox"/></p> <p>Tel: 01423 553464</p> <p>Electronic referrals accepted via SystemOne Email: Contact the team for further details</p> <p>Urgent hospital referrals: Tel: 07388 956913 07748 920466 07388 956912</p>	<p>2. Saint Michael's Hospice</p> <p>Inpatient unit (GPs and PCT only) <input type="checkbox"/></p> <p>Day Therapy Unit <input type="checkbox"/></p> <p>Palliative Lymphoedema Clinic <input type="checkbox"/></p> <p>Neurological Conditions CNS <input type="checkbox"/></p> <p>Volunteer Visitor Service <input type="checkbox"/></p> <p>Physiotherapy (internal referrals only) <input type="checkbox"/></p> <p>Occupational Therapy (internal referrals only) <input type="checkbox"/></p> <p>Social Work (internal referrals only) <input type="checkbox"/></p> <p>Spiritual/pastoral service (internal referrals only) <input type="checkbox"/></p> <p>Fax: 01423 815454 Tel: 01423 879687</p> <p>Urgent referrals only Tel: 01423 872658</p>
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Patient Name:	NHS no:
Prefers to be called:	Hospital no:
Address:	Date of birth:
	Telephone:
	Mobile no:
Key code:	Lives alone: Yes / No
Does the patient have communication issues? Yes/No	
If yes, what are they?	
Current location of Patient:	
Home <input type="checkbox"/>	
HDFT <input type="checkbox"/> Ward _____	Date of admission _____
Other Hospital <input type="checkbox"/> Location _____	
Care Home <input type="checkbox"/> Name _____	

NOK/contact name:	GP:
Relationship:	Surgery:
Telephone number:	Tel:
Is this person Next of Kin? Yes/No	Nursing/other care teams involved:
Main Carer? Yes/No	
Has patient consented to referral? Yes/No	
Is relative aware of referral? Yes/No	

Diagnosis, treatment & relevant medical history:

MAIN CONCERNS - REASON FOR REFERRAL (referrals can be for physical, psychological, social and spiritual problems):

Continue on separate sheets

Is a DNACPR in place? Yes / No

Saint Michael's Hospice referrals ONLY:

Detail any supportive interventions e.g. PEG feeding, NIV, oxygen (NB if on oxygen specify L/min)

If patient smokes are they aware that they cannot smoke within the hospice building? YES / NO / N/A

Level of mobility (e.g. aids used):

Access to patient's home (e.g. steps, flat, multi-level etc):

Name of referrer:

Date of referral:

Position:

Contact no:

Date / time referral received:

By:

Signature: