

Community Specialist Palliative Care Referral Form

South West Surrey, North West Surrey, Rushmoor & Hart

Beacon Community Specialist Palliative Care, Guildford	Midhurst Macmillan Community Team	Phyllis Tuckwell Hospice, Farnham	Sam Beare Hospice, Weybridge	Woking Hospice, Woking
Tel: 01483 783400 Fax: 01483 783401	Tel: 01730 811121 Fax: 01730 816049	Tel: 01252 729400 Fax: 01252 729405	Tel: 01932 826095 Fax: 01932 826094	Tel: 01483 881750 Fax: 01483 881759

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Patient Details		Male <input type="checkbox"/> Female <input type="checkbox"/>	Patient aware of Specialist Palliative Care Referral? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Surname		DOB	Age	
First Name		Known as		GP aware of Referral YES <input type="checkbox"/> NO <input type="checkbox"/>
Address		Ethnic status		
		White British <input type="checkbox"/>	White Irish <input type="checkbox"/>	Other White <input type="checkbox"/>
		Mixed white/black Caribbean <input type="checkbox"/>		Mixed white/black African <input type="checkbox"/>
		Mixed white Asian <input type="checkbox"/>	Other mixed <input type="checkbox"/>	Pakistani <input type="checkbox"/>
Tel	Postcode	Indian <input type="checkbox"/>	Black African <input type="checkbox"/>	Other Asian <input type="checkbox"/>
NHS No		Chinese <input type="checkbox"/>	Other <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>
		Bangladeshi <input type="checkbox"/>	Other black <input type="checkbox"/>	Not stated <input type="checkbox"/>

Marital status: Married Single Divorced Widowed Co-habiting Separated

Next of Kin/Patient Representatives	General Practitioner
Name	Name
Address	Surgery
Telephone	Postcode
Relationship to Patient	Telephone
	Fax

Main Carer (if different from above)	District Nurse	Matron
Name	Name	
Tel	Based at	
Relationship to Patient	Telephone	
	Fax	

Other Services/Professionals involved: Other e.g. Keyworker:

Consultant:

Hospital:

Reason for Referral	Service Requested	The patient is currently
Pain/symptom management <input type="checkbox"/>	Assessment at home <input type="checkbox"/>	At home <input type="checkbox"/>
Emotional/psychological distress <input type="checkbox"/>	Assessment – community hospital <input type="checkbox"/>	Other <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Beacon Assessment & <input type="checkbox"/>	
Carer Support <input type="checkbox"/>	Therapy Unit <input type="checkbox"/>	
Palliative Rehabilitation <input type="checkbox"/>	Out-patient assessment <input type="checkbox"/>	
Other (Please specify) <input type="checkbox"/>	Day Hospice <input type="checkbox"/>	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Admission for Respite <input type="checkbox"/>	
	Symptom control/terminal care <input type="checkbox"/>	

If patient in hospital, please complete the following:

Hospital:	Telephone:
Ward:	Date of discharge
Consultant 1:	Direct tel:
Consultant 2:	Direct tel:
	Is Hospital Palliative Care Team involved? YES/NO
	MRSA status Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/>

IS REFERRAL URGENT (advice/assessment within 2 working days)? YES NO
IF URGENT, PLEASE PHONE FOR IMMEDIATE ADVICE

Patient Name:

DoB:

NHS No:

Primary Diagnosis

Brief History of Diagnosis(es) & Key Treatments

Date

Progression of Disease, Investigations & Treatments

Current Problems

Any other problems/information (including psychosocial or spiritual issues)

Social Situation

Any barriers to communication:

Past Medical & Psychiatric History

Known Drug Sensitivities/Allergies YES NO
Specify:

PLEASE ATTACH DETAILS OF ALL CURRENT MEDICATION

Has the patient been fitted with: Cardiac pacemaker Yes No

Implantable Cardiac Defibrillator Yes No Radioactive or other implant Yes No

Has patient been told diagnosis? Yes No Is the carer aware of patient's diagnosis? Yes No

Does patient discuss the illness freely? Yes No Does the carer discuss the illness freely? Yes No

Please ensure patients are aware information will be held on computer according to the Data Protection Act

Referrer's signature:

Name (please print)

Job Title:

Contact Tel:

Surgery or Hospital:

Bleep No:

Fax No:

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INSUFFICIENT INFORMATION MAY DELAY PATIENT ASSESSMENT**