|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | **Title** | **Forename** | **Surname** | **Preferred name** |
| **DOB** | **Age** | **Main language** | **Communication needs/ Interpreter required** Y/N |
| **Gender** | **Ethnic origin** | **Religion** |
| **NHS Number** | **Email address** |
| **Current Address****Post code** | **Contact number****Day time****Evening****Mobile** |
| **Current Location** | **Diagnosis** |
| **Home** |  | **Hospital** |  | **Other (specify)** |  |  | **Prognosis****(Please ref to SPICT)** | **Years** | **Months** | **Weeks** | **Days** |
| **Contact no** (if different from above): |  |  |  |  |
| **Supporting Consultant:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REFERRER** | **Title:** | **Forename:** | **Surname:** | **Date last seen by referrer:** |
| **Referral source:** | **Contact no** | **Email Address:** |
| **DN team (if applicable):** | **Hospice site (if request for IPU Admission)** | **RESPECT form in place** Y/N |
| **Anticipatory Meds in place** Y/N |

|  |  |
| --- | --- |
| **REASON FOR REFERRAL** |  |
| **Symptom Control** |  | **Therapies/ Wellbeing** |  | **Bereavement Support** |  | **Personal Care** |  |  |
|  |
| **End of life care** |  | **Day Services** |  | **Respite** |  | **OPA/Clinic** |  |  |
|  |
| **How can we help? (Please include main diagnosis, brief PMH, and current treatment plan. If symptom management required, please indicate the symptoms and medication/doses that have been tried.)** | *Please attached any appropriate clinical annotations with the referral to us and include any useful information such as housing issues / drug / alcohol dependency etc* |
| **Urgency** | **Urgent – 2 days** |  | **5 days** |  | **10 days** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GP** | **GP** | **Practice** | **Contact no** | **Email address** |
| **Hospital** | **Is patient on Palliative Care Register/GSF** Y/N |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NOK / CARER**  | **Title** | **Forenames** | **Surnames** | **Relationship**  |
| **Address** |
| **Post Code** | **Contact number** |

**Please ensure NOK/Carer has been Identified by the patient.**

|  |  |
| --- | --- |
| **AUTHORISATION** | **Is patient aware of the referral and agrees to participate in information being shared Y/N** *(If No, please supply a reason)* |