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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | | | | | | | | | |

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| **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 | |

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| **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** |  | |  |

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

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| --- | --- | --- | --- | --- | --- |
| **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)* |