South Essex Palliative and Supportive Care Network

NHS

REFERRAL FORM

PLEASE TICK SERVICE(S) REQUIRED AND FAX ONCE COMPLETE: ✔

Service	Fax	✔	Service	Fax	✔
ST Luke's Hospice	**DAY HOSPICE** Fax No: 01268 282483 **INPATIENT**		**Fairhaven's Hospice**	**DAYCARE** Fax No: 01702 437009 **INPATIENT**	
Basildon Hospital Palliative Care Team	Fax No: 01268 593326		**Southend Hospital Palliative Care Team**	Fax No: 01702 221413	
Community Macmillan Palliative Care Team Basildon, Thurrock, Billericay, Wickford areas	Fax No: 01268 448522		**Community Macmillan Palliative Care Team** Southend, Benfleet, Rochford, Canvey Island areas	Fax No: 01702 433347	
Hospice at Home Basildon & Thurrock **Urgent referrals PHONE**	Fax No: 01268 530552 **07739890140 (fax later)**		**Hospice at Home** Southend **Urgent referrals PHONE**	Fax No: 01702 339365 **07850 613445 (fax later)**	

SURNAME:-

FIRSTNAME:

PREFERRED NAME:-

NHS NO:-

Male: ☐ **Female:** ☐

ADDRESS:

POSTCODE:

DATE OF BIRTH:

TELEPHONE No: HOME:

WORK:

MOBILE:

NEXT OF KIN:

Relationship:

Aware of diagnosis: **Y** ☐ **N** ☐

Address (If different to pt)

Telephone No: Home:

Work:

Mobile:

MAIN CARER (If not N.O.K.)

Relationship: Tel:

Address (if different to pt)

ETHNIC GROUP:

PREFERRED LANGUAGE:

RELIGION/BELIEF SYSTEM:

MARITAL STATUS:

Married: ☐ Widowed: ☐ Single: ☐

Divorced: ☐ Co-Habiting ☐ Separated: ☐

PRIMARY DIAGNOSIS:

DATE of DIAGNOSIS:

Sites of any Secondary Spread:

GENERAL PRACTITIONER:

SURGERY DETAILS:

TELEPHONE NO:

PATIENT AWARE of DIAGNOSIS: **Y** ☐ **N** ☐

OTHER MEDICAL CONDITIONS:

PATIENTS NAME: **DATE of BIRTH:**

NHS NO:

OTHER SERVICES INVOLVED:	**Patient Known to Service**	**Referred**	**Date**
DISTRICT NURSE Name: Base & Tel No:	☐	☐	
SOCIAL WORKER: Name: Base & Tel No:	☐	☐	
SITE SPECIFIC CLINICAL NURSE SPECIALIST: Name: Base & Tel No:	☐	☐	
OCCUPATIONAL THERAPIST: Name: Base & Tel No:	☐	☐	
HOSPICE AT HOME:	☐	☐	

HOSPICE AT HOME REFERRALS HEALTH & SAFETY ISSUES

Access to Home:

Equipment in Use:

Manual Handling Issues:	Tick ✔
Mobile:	☐
Bed / Chair Bound:	☐
Weight Bearing:	☐
Not Weight Bearing:	☐
Environmental Risks:	☐
Risk of Falls:	☐

CONSULTANTS INVOLVED: (not initials) **SPECIALITY:** **HOSPITAL:** **HOSPITAL NUMBER:**

ALERT	INFECTION RISK MRSA / C DIFF	DRUG ALLERGY	CONFIDENTIALITY ISSUE	SOCIAL/HOME ISSUE	OTHER
	☐	☐	☐	☐	☐

Please Give Details:

Preferred Place of Care	**HOME**	**NURSING HOME**	**HOSPICE**	**HOSPITAL**	**PREFERRED PLACE OF CARE DOCUMENT**
PATIENT					**YES:**
FAMILY					**NO:**

DETAILS OF REFERRAL to SPECIALIST PALLIATIVE CARE SERVICES (SPC)

NAME OF REFERRER: DESIGNATION:

CONTACT DETAILS OF REFERRER:

REFERRAL DATE:

PATIENT & CARER AWARE OF REFERRAL & AGREEABLE TO TRANSFER OF INFORMATION: **YES** ☐ **NO** ☐

REASON for REFERRAL		**ADDITIONAL INFORMATION**
PSYCHOLOGICAL SUPPORT	☐	
SYMPTOM CONTROL	☐	
RESPITE CARE	☐	
TERMINAL CARE	☐	
ASSESSMENT	☐	
OTHER	☐	
Please state:		

ONWARD REFERRAL and UPDATE for SPECIALIST PALLIATIVE CARE PROVIDERS

PATIENTS NAME: **DATE OF BIRTH:** **NHS NO:**

DATE:

REASON for REFERRAL:

TREATMENT (please detail)

MEDICATION:

SUMMARY:

EXPECTED DATE of DISCHARGE:

NAME of REFERRER: **SIGNATURE:**

CONTACT TELEPHONE NO: **DESIGNATION:**