**St Nicholas Hospice Services Referral Form v14**

***24 Hour telephone advice available 01284 766133 – Referral Form not required***

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| **Patient** Title  Surname       First name       Middle names  Date of birth    /  /      Male  Female | |
| **Referred by** (your name)               Job title            Contact Tel  **Referral date**  /  / Time faxed       Availability if limited  **Referred via The Burton Centre, Haverhill** Yes: No: | |
| Are you referring **the patient** Yes  No  or **family member(s)** Yes  No  or **both** Yes  *If family members please also give full patient details below*  **Is patient aware of referral** Yes  No  **Is family aware of referral** Yes  No  **HAS PATIENT CONSENTED TO SHARE THEIR RECORDS** Yes  No | |
| **Address**    Postcode | **Phone No’s** Home  Work  Mob |
| **Who else lives at this address:** *Please highlight the name of the carer you want to refer to our service in their own right*  Name(s)       Relationship        Relationship  Main carer if different to the above:  Address/phone number if different to patient  Family name if different to patient | |
| **What unmet needs have triggered this referral now?** | |
| **What is it that you are hoping we can do?** | |
| **Present location of patient**   1. Home: Yes  Are there any hazards in the home No  Yes  (please detail) 2. Hospital: Yes  West Suffolk  Addenbrooke’s  Papworth  Other   Ward Name/No       Ward direct-dial tel   1. Care Home: Yes  Name of Home             Tel   **Proposed discharge date** (if 2 or 3): /  / | |

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| **Patient’s diagnosis:** *Please note we welcome referrals for people with diseases other than cancer* | | | | |
| **If cancer:**  Primary(ies)  Secondaries | | | | Dates Diagnosed |
| **Patient’s treatments/investigations – past, current and planned** | | | | |
| **Patient’s relevant Medical History**  Medical    Psycho-social  Recent bereavement(s)/losses | | **Current medications** | | |
|  | |  | | |
| **Allergies** YesNo Not known  If yes, give details | | | | |
| **CDIFF** +ve  -ve  Not known  **MRSA** +ve  -ve  Not known  MRSA Details: | **Ethnicity** | |  | |
|  | **Religion** | |  | |
| **Does the person or family have any mobility, disability, communication/language issues?**  Yes  No  If yes, please describe | | | | |
| **GP** name  Surgery  Tel No  Is GP aware of referral? Yes  No  **If no** - please inform  Date GP informed      /     /  Is District Nurse aware of referral? Yes  No  Date DN informed      /     /  On GSF Register Yes  No  DS 1500 completed Yes  No | **Consultant(s)** **Hospital** Tel No(s)                   NHS No  Hospital No | | | |
| **What other professionals/support services are involved? (Names, Roles & Tel No)** | | | | |
| **What are your plans for follow up?** | | | | |
| **How do you wish to be informed of St Nicholas’ response to this referral?**  Tel  Fax  Letter  other - please specify       **Your contact details:**  **Please attach** Copies of discharge summaries  Medical letters  Drug list/EMIS printout  Detailed pre admission information is required before any admissionto the hospice ward | | | | |