**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** Yes **[ ]** No **[ ]**  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 informDate 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  |