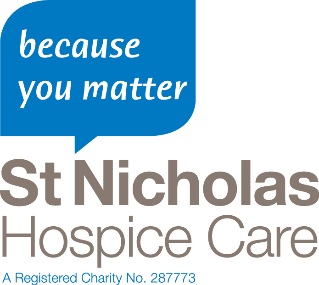
**St Nicholas Hospice Care** Services Referral Form

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRER DETAILS** | | | | | | | | | | |
| **Name** | | | |  | | **Date** | |  | | |
| **Job title/**  **Relationship**  **to patient** | | | |  | | **Telephone** | |  | | |
| **Email** | |  | | |
| **Signature** | | | |  | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | |
| **Title** | |  | **Surname** |  | **First**  **name** |  | | **Middle name** |  | |
| **Date of birth** | | | |  | **Male**  **Female  Other** | | | **NHS no.** |  | |
| **Preferred language** | | | |  | **Ethnicity** |  | | **Religion** |  | |
| **Address** | | | |  | | **Phone number**  Please tick to indicate which number is preferred and document whether a message can be left | | Home:  Work:  Mobile: | | |
| **Who are you**  **referring?** | | | | The patient  or  Family member(s) | | **Is patient aware of referral?**  The referral cannot be processed unless the patient or advocate is aware of the referral and consent has been given. | | Yes  No  If no reason why not asked: | | |
| **Name/relationship to patient** | | | |  | | **Family aware of referral** | | Yes  No | | |
| **HAS PATIENT CONSENTED TO SHARE THEIR RECORDS WITH**  **ST NICHOLAS HOSPICE CARE** | | | | | | | | Yes  No | | |
| **NEXT OF KIN** | | | | | | | | | | |
| **Title** |  | | **Surname** |  | | **First name** | |  | | |
| **Address** | | | |  | | **Relationship to patient** | |  | | |
| **Phone number** | |  | | |
| **MEDICAL** | | | | | | | | | | |
| **DIAGNOSIS:**  **Primary:** | | | |  | | **Patient aware of diagnosis**  Yes  No  **Family aware of diagnosis**  Yes  No | | | | |
| **Secondary:** | | | |  | |
| **Past medical history** | | | |  | | | | | | |
| **My care wishes folder** | | | | Yes  No | | **DNACPR** | | Yes  No | | |
| **Reason for referral** | | | | Symptom Control  Bereavement  Psychological Support  Social Crisis  End of Life Care  Other | | | | | | |
| **Details (mandatory):** | | | |  | | | | | | |
| **Service required** | | | | Inpatient Care  Outpatient/Community | | | | | | |
| **Allergies** | | | | Yes  No  Not known | | If YES please give details: | | | | |
| **CDIFF** | | | | +ve  -ve  Not known | | **MRSA** | | +ve  -ve  Not known | | |
| **Any other**  **infection risk** | | | | Yes  No | | If YES please give details: | | | | |
| **Present location of patient** | | | | **Home** | | **Are there any hazards in the home?** | | Yes  No  If YES please give details: | | |
| **Hospital** | West Suffolk Ward | | Addenbrooke’s Ward | | Other ward |
| **Care Home** | | **Name of care home** | |  | | |
| **Telephone** | |  | | |
| **GP DETAILS** | | | | | **OTHER HEALTHCARE PROFESSIONALS** | | | | | |
| **GP Name** | | | |  | **Consultants/CNS** | | **Hospital** | | **Telephone** | |
| **Surgery** | | | |  |  | |  | |  | |
| **Tel No** | | | |  |  | |  | |  | |
|  | | | | | | | | | | |
| **Any environmental risks** | | | | Yes  No  Not known | | If YES please give details: | | | | |