**St Nicholas Hospice Care** Services Referral Form

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

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| --- |
| **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 [ ]  NoIf 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: |