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Broad Lane, Rochdale, OL16 4PZ

**Tel.** 01706 649920

**Email.** hmrccg.liaison@nhs.net

**REFERRAL FORM**

**WELLBEING & SUPPORTIVE CARE**

**\*\*Please attach any relevant clinical information/letters/contact assessments\*\***

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| --- |
| **Is the patient aware that this referral has been made? Yes □ No □**  **Is the patient’s GP aware that this referral has been made? Yes □ No □**  **\*\*Please note this referral will only be processed if the patient is aware and has given consent\*\*** |

**PATIENT DETAILS:**

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First name: | Gender: |
| Address: | Ethnicity: |
| Language: |
| Postcode: | Marital status: |
| Tel. No. |  |

**PATIENT INFORMATION:**

|  |  |
| --- | --- |
| Diagnosis: | Location of patient: |
| Date of Diagnosis | Home □ |
| Hospital Number: | Hospital □ (please specify Hospital & ward) |
| NHS Number: | Does the patient live alone? Yes □ No □ |

**NEXT OF KIN / CARER DETAILS:**

|  |  |
| --- | --- |
| Surname | Address: |
| First name: |
| Relationship to patient | Postcode: |
| Tel. Number: |

**Referrer details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Address: | | Tel. Number: | |
| GP □ | Consultant □ | Specialist Nurse □ | | District Nurse □ | | Other □ (specify) |

**GP/OTHER SERVICES INVOLVED:**

|  |  |
| --- | --- |
| GP name:  Address:  Tel. Number:  Fax: | Specialist Nurse name:  Tel. Number: |
| District Nurse Name:  Tel Number |
| Other (please specify) |

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| --- |
| **Reason for referral:** *(Please indicate current problems and specific aims of referral)* |

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| **Other relevant medical history:** *(Past medical history, other current illnesses, treatments, outcomes, prognosis)* |

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| **Nursing/Physical:** *(Activities of Daily Living, bowels, appetite, mobility, dressings, wounds, IV therapies, day-to-day nursing needs of patient)* |

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| **Social situation:** *(Housing, family, financial, community support, access to property, are there any foreseeable risks?)* |

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| **Emotional/psychological/spiritual/insight:** *(Knowledge of illness, prognosis, feelings and fears, importance of religion, communication barriers for both patient & carer, ability to make decisions)* |

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| **Present medication:** *(Please list medication, dose and frequency here OR send current drug list)* |

|  |  |
| --- | --- |
| **Dementia and Carer support Programme** □  **Wellbeing Programme** □ |  |

|  |  |
| --- | --- |
| **Further information:**  North West Model for Life Limiting Conditions  Advance Care Plan Yes □ No □  uDNACPR form? Yes □ No □ | Key-safe in place Yes □ No □  Preferred place of care Yes □ No □  (if yes, please state where …………………………. ) |

|  |  |
| --- | --- |
| **Person completing referral:**  Print Name:  Signature: | Designation:  Tel No:  Date: |