SPRINGHILL HOSPICE
Making every moment count

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REFERRAL FORM

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

Service(s) requested:

Inpatient Unit Admission (tick one only)	Symptom Control ☐	End of Life Care (in last days of life) ☐

Community Services (tick all required)	Community Specialist Palliative Care Nurse ☐	Medical Outpatient Clinic ☐	Day Hospice Service ☐	Hospice at Home (last days/weeks of life) ☐	Night Sitting Service ☐	24 Hr Advice Line ☐

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 and/or family are aware and have given consent****

Patient details:

Surname:	Date of Birth:
First name:	Sex:
Address:	Ethnicity:
	Language:
Postcode:	Interpreter required?
Tel. No.	Marital status:

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:	
	Postcode:
Relationship to patient	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)

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

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

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

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

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

Present medication: *(drug. dose, frequency (or send current list)*

Further information:					
GSF register	Yes ☐	No ☐	Continuing Healthcare Funding	Yes ☐	No ☐
DS1500 issued	Yes ☐	No ☐	Care package in place	Yes ☐	No ☐
Advance Care Plan	Yes ☐	No ☐	Key-safe in place	Yes ☐	No ☐
Anticipatory drugs prescribed	Yes ☐	No ☐	Preferred place of care	Yes ☐	No ☐
uDNACPR form?	Yes ☐	No ☐	(if yes, please state where ……..)		

Person completing referral:	Designation:
Print Name:	Tel No:
Signature:	Date: