REFERRAL FORM

South Essex Palliative and Supportive Care Network

PLEASE TICK SERVICE(S) REQUIRED AND FAX ONCE COMPLETE: ✔ ✔

St. Luke's Hospice	**DAYCARE** Fax No: 01268 282483 **INPATIENT**		**Fairhaven's Hospice**	**DAYCARE** Fax No: 01702 437009 **INPATIENT**	
Basildon Hospital Palliative Care Team	Fax No: 01268 593326		**Southend Hospital Palliative Care Team**	Fax No: 01702 385886	
Community Macmillan Palliative Care Team Basildon, Thurrock, Billericay, Wickford areas	Fax No: 01375 373136		**Community Macmillan Palliative Care Team** Southend, Benfleet, Rochford, Canvey Island areas	Fax No: 01702 341341	
Hospice@Home Basildon & Thurrock **Urgent referrals PHONE**	Fax No: 01268 530552 **07739 890140 (fax later)**		**Hospice@Home** Southend **Urgent referrals PHONE**	Fax No: 01702 339365 **07850 613445 (fax later)**	

SURNAME:

FIRST NAME:

PREFERRED NAME:

NHS NO:
(must be completed)

Male: ☐ **Female:** ☐

ADDRESS:

POSTCODE:

DATE OF BIRTH:

TELEPHONE NO: HOME:

WORK:

MOBILE:

NEXT OF KIN:

Relationship:

Aware of diagnosis: **Y** ☐ **N** ☐

Address (if different to patient)

Telephone No: Home:

Work:

Mobile:

MAIN CARER (if not N.O.K.)

Relationship: Tel:

Address (if different to patient)

ETHNIC GROUP:

PREFERRED LANGUAGE:

RELIGION/BELIEF SYSTEM:

MARITAL STATUS:

Married: ☐ Widowed: ☐ Single: ☐

Divorced: ☐ Co-Habiting ☐ Separated: ☐

PRIMARY DIAGNOSIS:

DATE OF DIAGNOSIS:

Sites of any secondary spread:

GENERAL PRACTITIONER:

SURGERY DETAILS:

TELEPHONE NO:

PATIENT AWARE OF DIAGNOSIS: **Y** ☐ **N** ☐

OTHER MEDICAL CONDITIONS:

PATIENTS NAME: **DATE OF BIRTH:** **NHS NO:**

OTHER SERVICES INVOLVED:	**Patient known to service:**	**Referred:**	**Date:**
DISTRICT NURSE Name: Base & Tel No:	☐	☐	
SOCIAL WORKER: Name: Base & Tel No:	☐	☐	
SITE SPECIFIC CLINICAL NURSE SPECIALIST: Name: Base & Tel No:	☐	☐	
OCCUPATIONAL THERAPIST: Name: Base & Tel No:	☐	☐	
HOSPICE AT HOME:	☐	☐	

HOSPICE AT HOME REFERRALS
HEALTH & SAFETY ISSUES

Access to Home:

Equipment in Use:

Manual Handling Issues: Tick ✔

Mobile: ☐

Bed / Chair Bound: ☐

Weight Bearing: ☐

Not Weight Bearing: ☐

Environmental Risks: ☐

Risk of Falls: ☐

CONSULTANTS INVOLVED: (not initials) **SPECIALITY:** **HOSPITAL:** **HOSPITAL NUMBER:**

ALERT

INFECTION RISK MRSA / C DIFF	DRUG ALLERGY	CONFIDENTIALITY ISSUE	SOCIAL/HOME ISSUE	OTHER
☐	☐	☐	☐	☐

Please Give Details:

Preferred Place of Care	**HOME**	**NURSING HOME**	**HOSPICE**	**HOSPITAL**	**PREFERRED PLACE OF CARE DOCUMENT**
PATIENT					**YES**
FAMILY					**NO**

DETAILS OF REFERRAL TO SPECIALIST PALLIATIVE CARE SERVICES (SPC)

NAME OF REFERRER: **DESIGNATION:** **BASE:**

CONTACT DETAILS OF REFERRER:

REFERRAL DATE:

PATIENT & CARER AWARE OF REFERRAL & AGREEABLE TO TRANSFER OF INFORMATION: **YES** ☐ **NO** ☐

REASON FOR REFERRAL		**ADDITIONAL INFORMATION**
PSYCHOLOGICAL SUPPORT	☐	
SYMPTOM CONTROL	☐	
RESPITE CARE	☐	
TERMINAL CARE	☐	
ASSESSMENT	☐	
OTHER	☐	
please state:		

ONWARD REFERRAL AND UPDATE FOR SPECIALIST PALLIATIVE CARE PROVIDERS

PATIENTS NAME: **DATE OF BIRTH:** **NHS NO:**

PATIENTS ADDRESS: **G.P**

DATE:

REASON FOR REFERRAL:

TREATMENT (please detail)

MEDICATION:

SUMMARY:

EXPECTED DATE OF DISCHARGE:

NAME OF REFERRER: **SIGNATURE:**

CONTACT TELEPHONE NO: **DESIGNATION:** **BASE:**