

Pendleside Hospice Referral Form (updated Feb 2023)



Email: pendlesidehosp.referrals@nhs.net

Telephone: 01282 440100

Please complete as fully as possible to avoid delay in referral to the service

Has the patient consented to this referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the patient consented to sharing healthcare information e.g EMIS Sharing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the patient consented to receive appointments via SMS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Patient Name		Date of Birth		Age			
Address (incl. postcode)		Marital Status					
		Ethnicity					
		NHS Number					
		Current location of the patient					
		Does the patient live alone?		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Tel. Number		Mobile Number					

Referral Priority:	<input type="checkbox"/> Urgent (Ring 01282 440100)	<input type="checkbox"/> Soon	<input type="checkbox"/> Routine
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Referral for (tick all that apply)

INPATIENTS	HOSPICE AT HOME	DAY SERVICES	FAMILY SUPPORT	MEDICAL
<input type="checkbox"/> Assessment <input type="checkbox"/> Symptom Control <input type="checkbox"/> Last Days of Life <input type="checkbox"/> Rehabilitation <i>*Please be aware that the IPU is not a long term place of care</i>	<input type="checkbox"/> Hospice at Home <input type="checkbox"/> Extended Service (24hr care in last days of life – ring 01282 440106)	<input type="checkbox"/> Day Service <input type="checkbox"/> Complementary Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Drop In Clinic	<input type="checkbox"/> Pre-Bereavement Counselling <input type="checkbox"/> Post-Bereavement Counselling <input type="checkbox"/> Complementary Therapy	<input type="checkbox"/> Palliative Consultant assessment & review

Clinical Information

Diagnosis (incl date)	COVID-19 Symptoms? Temp/Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	⇒ Date of COVID-19 test		
	⇒ Result		

Site of Metastases:	Allergies:
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Reason for Referral (including current situation and problems)

Treatment (incl dates)	Relevant Past Medical History
Surgery:	
Chemotherapy:	
Radiotherapy:	
Hormone Treatment:	

Patient Name:	
Current Medication	
Next of Kin (name and address)	Relationship to patient
	Telephone no:
	Mobile no:
Main Carer (if different to Next of Kin)	Relationship to patient
	Telephone no:
	Mobile no:
Patient's GP	Telephone no:
Patient's Consultant	Telephone no:
District Nurse	Telephone no:
Specialist Palliative Care CNS	Telephone no:
Social Worker	Telephone no:
Other	Telephone no:
Current support provided by professional(s)	
Name of Referrer (Block Capitals)	Job Title:
	Organisation:
Inpatient Referrals: Please ensure that the patient/family are aware that the Hospice is not a long term place of care and discharge planning (<u>except end of life care</u>) will be discussed from point of admission onwards	
Telephone No:	Mobile No:
Signature:	Date:

Please email completed referral form to: Pendlesidehosp.referrals@nhs.net

Referrals can be made over the phone, if you are unable to email form