Self referral form – Day Hospice

Name: Male/Female:	Next of Kin Name:
Address: Postcode:	Next of Kin Address: Postcode:
Date of Birth: Tel No: Home/Mobile e-mail address: Preferred contact method:	Tel No: Home/Mobile: Work:

Name of your illness: Date of diagnosis (if known): Treatment:	Does your next of kin know about your illness: Yes/No	Main Carer:

Have you attended Willow Wood before? Yes/No

Reason for coming to Willow Wood:

GP Name Address: Tel No:	Name of any nurses involved in you r care: Name: Tel No: Name: Tel No:

Transport Required? Y/N	First language?	Other Barriers e.g. hearing loss, confusion, sight status

Consent

Signed ---------- Date----------

By signing this form, you are giving consent to Willow Wood's medical team to obtain your medical records from your GP or to access your hospital records