WILLOW WOOD HOSPICE PALLIATIVE CARE REFERRAL FORM

Tel: 0161 330 1100 Fax: 0161 330 1144

PATIENT DETAILS			**Office use only**
Name	male/female	Consent to referral Obtained? Yes/no	**Hospice no**
Address Post code	Phone Mobile	Patient has capacity? Yes/no Relative/IMCA aware of referral? Yes/no	**Date received** **Action** **IPU [ ] DH [ ]** **OPC[ ] DS [ ]**
Marital status	Ethnicity	GP aware? Yes/no	**Signature**
NHS No	DoB		

MAIN DIAGNOSIS
OTHER DIAGNOSES
OTHER INFORMATION

COMMUNICATION
Is a communication aid used/ interpreter needed?
Any other barriers to communication (e.g. hearing loss, confusion, cognitive impairment)?

NOK/ representative	**Social services**	**General practitioner**	**Specialist service**
Address	Base	Base	Service Base
Tel:	Tel:	Tel:	
Mobile:	Fax:	Fax:	Tel:
Relationship	CHC assessment? Yes/no	Email	Email
Main carer	**District nurse**	**Macmillan nurse**	**Consultant**
Address	Base	Base	Speciality
	Tel:	Tel:	Base
Tel:	Fax:	Email:	Tel:

Reason for referral	**Service required**	**Location of patient e.g. home/ hospital**
[ ] Terminal care	[ ] Outpatient clinic assessment	
[ ] Symptom control	[ ] Day Services	Address
[ ] Carer support/education	[ ] In-patient Unit	
[ ] Advance care planning	[ ] Dementia Service	
[ ] Deferred		Tel:
		Patient lives alone? Yes/no

Patient Name DoB

HOSPITAL IN-PATIENT DETAILS	
MRSA status negative [ ] positive [ ]	
History of C. difficile infection yes/no 48 hours clear of symptoms yes/no	
Date	History of diagnosis(es) and key treatments (with dates)
Surgery Chemotherapy Radiotherapy	
Relevant past medical/psychiatric history	
Allergies	

Current problems	
1	3
2	4
Mobility	
Independently mobile[ ] Mobile with assistance [ ] Wheelchair user [ ] Bed-bound [ ]	
Day hospice only: is transport required?	
Patient awareness of service offered at Hospice	
Has patient been informed that discharge planning (where applicable) commences on admission and social services may be involved as necessary? Yes [ ] No [ ]	
Has patient been informed of no smoking policy at hospice/ smoking cessation support available if needed? Yes [ ] No [ ]	

Any psychological, emotional, spiritual or family dynamics you feel we should be aware of?
Are you aware of any safeguarding issues regarding children or vulnerable adults? Yes [ ] No [ ] **Prognosis?**

Is the patient registered on the GSF?	Do they have a Multiprofessional Toolkit or other advance care plan?
Is there a lasting power of attorney? Name Contact details	Any advance directives to refuse treatment? DNACPR status: for CPR [ ] DNACPR [ ] unknown [ ]

Referrer's name:	Base
Job title	Contact no
Signature	Date

Please fax an up-to-date list of current medication along with GP medical summary with this referral. Thank you for your referral to Willow Wood Hospice