WILLOW WOOD REFERRAL FORM

Fax: 0161 330 1144 | Email: referrals.wwh@nhs.net

PATIENT DETAILS			**Office use only**
Name	male/female	Patient has capacity? Yes/No	**Hospice No**
Address Postcode	Phone Mobile	Relative/IMCA aware of referral? Yes/No	**Date Received** **Action** **IPU [ ] START [ ]** **OPC [ ] DS [ ]**
NHS No:	DoB:	GP aware? Yes/No	**Signature**

MAIN DIAGNOSIS			
Prognosis	**Days** ☐	**Weeks** ☐	**Months** ☐
OTHER IMPORTANT INFORMATION e.g. home circumstance, past medical history			

Current Problems	
1	3
2	4

NOK/representative	**Social Services**	**General Practitioner**	**Specialist Service**
Address	Base:	Base:	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	[ ] In-Patient Unit	Address
[ ] Symptom Control	[ ] START Clinic	
[ ] Carer Support/Education	[ ] Dementia Service	
[ ] Advance Care Planning	[ ] Outpatient Clinic Assessment	
[ ] Deferred		Tel:
		Patient Lives Alone?: Yes/No

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:	
Allergies:	

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 [ ]

COMMUNICATION			
Is a communication aid used/interpreter needed?			
Any other barriers to communication (e.g. hearing loss, confusion, cognitive impairment)?			
Mobility			
Independently Mobile [ ]	Mobile with Assistance [ ]	Wheelchair User [ ]	Bedbound [ ]
START Clinic only: Is transport required:			
Has patient been informed of no smoking policy at Hospice/smoking cessation support available if needed? Yes [ ] No [ ]			

Is the patient registered on the GSF? Yes [ ] No [ ]	Do they have a "My Care, My Way" or other advance care plan? Yes [ ] No [ ]
Is there a lasting power of attorney? Name: Contact Details:	Any advance directives to refuse treatment? DNACPR in place: Yes [ ] No [ ]

Referrer's Name:	Base:
Job Title:	Contact Number:
Signature:	Date:

Please send or fax an up-to-date list of current medication along with GP medical summary with this referral.

Willow Wood Hospice is acting as the data controller and the information we collect will be used strictly for the provision of health or social care as well as preventive or occupational medicine that is carried out in the public interest and will be stored for a maximum of up to 20 years. Data may be transferred to other organisations for the purposes of processing and the continued provision of health or social care as well as preventive or occupational medicine. We do not profile data in anyway, either manually or via automated decision making. You have the right to withdraw, correct, erase and restrict access of the information that we may store about you. Please contact our Data Protection officer on admin@willowwood.info for any requests of this nature. To see other ways in which we may use your data and how we store it, please see our Privacy Policy. If you feel that we are incorrectly processing your data, you have the right to object to the Information Commissioner's Office on 0303 123 1113.