Willow Wood
Caring for local people

PALLIATIVE CARE REFERRAL FORM

PATIENT DETAILS			**Office use only**
Name	male/female	Consent to referral obtained? Yes/No	**Hospice No**
Address Postcode	Phone Mobile	Patient has capacity? Yes/No Relative/IMCA aware of referral? Yes/No	**Date Received** **Action** **IPU [ ] START [ ]** **OPC [ ] DS [ ]** **Signature**
Marital Status	Ethnicity	GP aware? Yes/No	
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:	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	Address
[ ] Symptom Control	[ ] START Clinic	
[ ] Carer Support/Education	[ ] In-Patient Unit	
[ ] Advance Care Planning	[ ] Dementia Service	
[ ] Deferred		Tel:
		Patient Lives Alone?: Yes/No

Patient Name: DoB:

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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 [ ] Bedbound [ ]
START Clinic 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?
Prognosis:
Are you aware of any safeguarding issues regarding children or vulnerable adults? Yes [ ] No [ ]

Is the patient registered on the GSF? Yes [ ] No [ ]	Do they have a Multi-professional toolkit or other advance care plan? Yes [ ] No [ ]
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 Number:
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