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**HOSPICE COMMUNITY SERVICES REFERRAL FORM**

**\*\*Please complete this form in full with all requested information for each section. Incomplete forms will be returned\*\***

**\*\*Please attach any relevant clinical information/letters/contact assessments\*\***

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| **Community Services** (tick all required) | Specialist Community Palliative Care Nurses  □ | Hospice at Home Service **(for patients who are in last days/weeks of life)**  □ | Night Sitting Service **(N.B the patient must already be known to Hospice services if requesting night sits)**  □ |

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| **Is the patient aware that this referral has been made? Yes □ No □**  **Is the patient’s GP aware that this referral has been made? Yes □ No □**  **\*\*Please note this referral will only be processed if the patient and/or family are aware and have given consent\*\*** |

**Patient details:**

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First name: | Sex: |
| Address: | Ethnicity: |
| Language: |
| Postcode: | Interpreter required? |
| Tel. No. | Marital status: |

**Patient information:**

|  |  |
| --- | --- |
| Diagnosis: | Location of patient:  Home □ Hospital □ (please specify Hospital & ward) |
| Date of Diagnosis |
| NHS Number: | Does the patient live alone? Yes □ No □ |

**Next of Kin/Carer details: Please add NOK information**

|  |  |
| --- | --- |
| Surname | Address: |
| First name: |
| Relationship to patient | Postcode: |
| Tel. Number: |

**GP/Other services involved:**

|  |  |
| --- | --- |
| GP name:  Address:  Tel. Number:  Fax: | Specialist Nurse name:  Tel. Number: |
| District Nurse Name:  Tel Number |
| Other (please specify) |

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| **Reason for referral:** ***(Please indicate current problems and the specific aims of this referral).*** |

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| **Other relevant medical history: *(include information regarding past medical history, other current illnesses, treatments, outcomes, prognosis).*** |

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| **Nursing/Physical:** ***(include details of the patient’s ability to complete Activities of Daily Living, any bowel issues, appetite problems, mobility issues, any current dressings / wounds, IV therapies, the day-to-day nursing needs of patient, are they bariatric, on O2, any aerosol generating procedures etc.)*** |

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| **Social situation:** ***( Any current care package details, what is the current housing situation, whether living with family, any financial issues, any existing community support, issues with access to property, are there any foreseeable risks?)*** |

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| **Emotional/psychological/spiritual/insight:** ***(include information regarding the patients’ knowledge of their illness, their prognosis, feelings and fears, importance of religion, communication barriers (for both patient & carers), ability to make decisions)*** |

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| **Present medication:** ***(drugs, doses, frequency (or send current list)*** |

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| --- | --- |
| **Further information:**  GSF register Yes □ No □  Advance Care Plan Yes □ No □  Key-safe in place Yes □ No □  Preferred place of care Yes □ No □  (if yes, please state where …………………………. ) | SR1 form issued Yes □No **□**  Continuing Healthcare Funding Yes □ No □  Anticipatory drugs prescribed Yes □ No □  uDNACPR form? Yes □ No □ |

**Referrer details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Address: | | Tel. Number: | |
| GP □ | Consultant □ | Specialist Nurse □ | | District Nurse □ | | Other □ (specify) |

|  |  |
| --- | --- |
| Print Name:  Signature: | Tel No:  Date: |