Specialist Palliative Care Referral Form

St Peter & St James HOSPICE & CONTINUING CARE CENTRE

North Common Road, North Chailey,
Lewes, East Sussex. BN8 4ED
Tel: 01444 471598
Clinical Fax: 01444 471820

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Patient Details

Surname	Male/Female Age:	Patient consent to palliative care involvement Yes ☐ No ☐
First Name	Date of birth	Is GP aware of referral Yes ☐ No ☐
Address	Marital Status	Office Use:
	Ethnicity	
Postcode Tel	Mobile Tel	
NHS number	**Hospital No.**	

Primary diagnosis(es) with dates (NB There is a box overleaf to give details of disease and treatment history)

Communication

Fluent in English? ☐ Yes ☐ No (If 'no' proceed with remaining questions)	Other barriers to communication:
First Language if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes ☐ No ☐	

Next of Kin/Patient Representatives	District Nurse Yes ☐ No ☐	General Practitioner
Name	Name	Name
Address	Based at	Address
	Telephone	
Telephone	Fax	
Relationship to patient		Postcode
Main Carer (if different from above)	**Social Services Yes ☐ No ☐**	Telephone
Name	Name	
Telephone	Based at	Fax/email
Relationship to patient	Tel Fax	
	Continuing care assessment completed: Yes/No	PCT number:

Reason for Referral	Service requested	The patient is currently
Pain/symptom control ☐	Home assessment and support ☐	At Home ☐
Emotional/psychological support ☐	Hospital assessment ☐	In Hospital (see over) ☐
Social/financial ☐	Out-patient assessment ☐	Other e.g. Nursing Home ☐
Assessment for hospice admission ☐	Admission for: respite / symptom control terminal care ☐	Does patient live alone? Yes ☐ No ☐
Carer support		
Other reason (e.g. spiritual, lymphoedema) ☐	**Patient Mobility**	

Referrer's Name: (please print)	Contact number: Bleep no:
Hospital/Surgery:	**This information required on both pages if faxing**
Referral Date:	Date seen:

IS REFERRAL URGENT (advice / assessment within 2 working days)? Yes ☐ No ☐

IF URGENT, PLEASE PHONE FOR IMMEDIATE ADVICE

Specialist Palliative Care Referral Form (p2)

In-Patient details		Patient's name .....
Hospital		Telephone
Ward	Direct Ward Ext.	Date of discharge (if known)
Consultant 1	Direct tel:	Is Palliative Care team involved? Yes ☐ No ☐
Consultant 2	Direct tel:	**MRSA Status** Positive ☐ Negative ☐ Not known ☐
Admission date:		

Brief History of diagnosis(es) and Key treatments ****NB please enclose copies of recent correspondence****

Date	Progression of disease and investigations/treatment	Consultant and hospital

Current problems

1.	4.
2.	5.
3.	6.

Any other comments/information (including psychosocial or spiritual issues)

Referrer's expectation of current treatment (circle) symptom control / life prolonging / curative

Estimated prognosis (circle) days / weeks / months / years

Past Medical and Psychiatric History	**Current Medication**	
		Known Drug Sensitivities/Allergies: **Yes** ☐ **No** ☐
		Details:
Pacemaker? Yes ☐ No ☐		

Insight

Has patient been told diagnosis? Yes ☐ No ☐ Is the carer aware of patient's diagnosis? Yes ☐ No ☐

Does patient discuss the illness freely Yes ☐ No ☐

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature:	Name: (please print)
Job title:	Contact number: Bleep no:
Surgery or Hospital:	Date: