

Specialist Palliative Care Referral Form

Locality 3 of the Surrey, West Sussex and Hampshire Palliative and Supportive Care Network

East Surrey Hospital Palliative Care Team
01737 768511 extn 2660
Fax: 01737 231949

St. Catherine's Hospice
01293 447333
Fax: 01293 447 390

Other (please name)

IT IS ESSENTIAL TO SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Patient Details			
Surname	Male/Female	Age: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
First Name	Date of birth	Patient consent to palliative care involvement Yes <input type="checkbox"/> No <input type="checkbox"/>	
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	Other barriers to communication:
Fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No (If 'no' proceed with remaining questions)	
First Language if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Next of Kin/Patient Representatives	District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	Telephone
Name	Name	Fax/email
Telephone	Based at	PCT number:
Relationship to patient	Tel Fax	
	Continuing care assessment completed: Yes/No	
Reason for Referral	Service requested	The patient is currently
Pain/symptom control <input type="checkbox"/>	Home assessment and support <input type="checkbox"/>	At Home <input type="checkbox"/>
Emotional/psychological support <input type="checkbox"/>	Hospital assessment <input type="checkbox"/>	In Hospital (see over) <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Out-patient assessment <input type="checkbox"/>	Other e.g. Nursing Home <input type="checkbox"/>
Assessment for hospice admission <input type="checkbox"/>	Admission for: respite / symptom control <input type="checkbox"/>	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Carer support <input type="checkbox"/>	terminal care <input type="checkbox"/>	
Other reason (e.g. spiritual, lymphoedema) <input type="checkbox"/>	Patient Mobility	
Referrer's Name: (please print)	Contact number:	Bleep no:
Hospital/Surgery:	This information required on both pages if faxing	

Patient's name

IS REFERRAL URGENT (advice / assessment within 2 working days)? Yes No
IF URGENT, PLEASE PHONE FOR IMMEDIATE ADVICE

