East Cheshire Hospice Palliative Care Referral

East Cheshire Hospice
Making every day count

PLEASE COMPLETED ALL FIELDS ON PAGE 1+2

Fax No 01625 665697

TO PROCESS REFERRALS WITHOUT DELAY PLEASE ENSURE YOU SEND:-

- **COPIES OF HOSPITAL CORRESPONDENCE**
- **MEDICATION SUMMARY**
- **PAST MEDICAL HISTORY**

For Hospice Use Only

Referral received ___ /____ / _____

Patient ID Number _____

GREEN AMBER RED

1 Patient Details

Title Mr / Mrs / Ms / Miss / Other _____

Surname _____

Forename(s) _____

Date of Birth ____ /____ / ___ Ethnicity_____

Home Address _____

_____

Post Code _____ Religion_____

Telephone ☎ _____

Mobile ☎ _____

Does the Patient Live Alone? Yes ☐ No ☐

Is the Patient Aware of:

Referral ☐ Diagnosis ☐ Prognosis ☐

Where is the patient at present?

Home ☐ Nursing Home ☐
Residential Home ☐ Hospital ☐
Other ☐

Please give details/ Ward Location_____

Patient's NHS Number ☐☐☐ ☐☐☐ ☐☐☐☐

Name of Next of Kin _____

Relationship to Patient _____

Next of Kin Address _____

Next of Kin Tel ☎ _____

Mobile ☎ _____

Is the Family Aware?

Referral ☐ Diagnosis ☐ Prognosis ☐

2 Patient's GP Details

GP Name _____

Practice Address/Practice Stamp

_____

_____

Post code _____

Telephone ☎ _____

Any known allergies (please specify)

_____

Infection Risk Information (please specify)

_____

3 Reason for Referral

Is this referral

Hold on file until further request ☐
For action soon ☐
For URGENT action ☐

Inpatient Admission

Symptom Management ☐
Crisis Respite ☐
Optimisation / Rehabilitation ☐
End of life care ☐

Sunflower Centre

Day Care Assessment ☐
Living Well ☐
OT Assessment ☐
Breathlessness Programme ☐
Fatigue Management ☐
Lymphoedema Assessment ☐
Art/ Psychotherapy ☐
Complementary Therapy ☐

Physiotherapy Assessment

Hospice / Community (**please circle)** ☐

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Inpatient Unit ☎ 01625 665683 or Sunflower Centre ☎ 01625 665685

4 Clinical Information about the Patient

Primary Diagnosis _____

Where diagnosis made _____ Date of Diagnosis ____ /____ / _____

Method of Diagnosis (biopsy/scan etc) _____

Site(s) of Metastases if appropriate_____ Date of Diagnosis ____ /____ / _____

Details of any treatment (surgery, XRT, chemotherapy etc…) and dates:

_____

_____

Palliative Care Needs (please be specific and include relevant psychosocial issues):

_____

_____

Significant previous history?

_____

_____

The hospice may need to contact the referring clinician for further details in order to make admission decisions

Hospital Details

Consultant _____ Hosp No _____ @ Hospital _____

Consultant _____ Hosp No _____ @ Hospital _____

Does the patient have a Community Social Worker? Yes ☐ No ☐ Name _____

Does the patient have a Macmillan Nurse/ Community Matron or other Specialist Nurse? Yes ☐ No ☐

Name _____ Designation _____

Does the patient have Continuing Health Care Funding? Yes ☐ No ☐

Patients preferred PPD/PPC _____ DNACPR YES / NO (please circle)

5 Requesting General Practitioner / Health Professional

Name (Please Print) _____

Signature _____

Designation _____ Contact Number_____

Date ____ /____ / _____

If the referring clinician is not the patient's GP/Consultant, please complete the following-

Name of GP/Consultant _____

Referral discussed/agreed with the patients General Practitioner Yes ☐ No ☐

Date of discussion _____