East Cheshire Hospice
Blood Transfusion / Infusion Referral Form

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 SUMMAY**
- **PAST MEDICAL HISTORY**

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 ☐

Hospital ☐ Residential Home ☐

Other ☐

Please give details / Ward Location _____

Patient NHS Number _____

Name of Next of Kin _____

Relationship to Patient _____

Next of Kin Tel ☎ _____

Next of Kin Mobile ☎ _____

Is the Family Aware?

Referral ☐ Diagnosis ☐ Prognosis ☐

For Hospice Use Only

Referral received ____ /_____ / _____

Patient EMIS Number _____

2 Patient's GP Details

G P 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 for a:

Blood Transfusion ☐

NOTE: - The Patient is required to attend for cross match blood test and will be booked in for a transfusion within 72 hours. The patient needs to be able to make their way to the Hospice Sunflower Centre without the use of hospital transportation.

A medical assessment will be carried out on the day of cross match by the Advanced Nurse Practitioner, prior to the transfusion, to assess the suitability of the patient for a day case admission. If we feel that the patient requires an overnight stay we will liaise with both the referrer and the patient to discuss this in advance. Following transfusion the patient will be transferred back to your care to follow up.

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The patient needs to have someone with them for 24 hours post transfusion

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Inpatient Unit ☎ 01625 665683 or Sunflower Centre ☎ 01625 665685

4 Clinical Information about the Patient

Name _____ DOB ____ /____ / ____

(to ensure patient safety when faxing please complete patient details on both forms)

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:

_____

Significant Past Medical History / Cardiac / Renal Impairment _____

_____

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

Reason for Transfusion / infusion: - _____

Is the patient symptomatic Yes / No (Please give details) _____

Most Recent Blood Results Dated > _____ (Within a week of referral)

Sodium _____ Bil _____
Potassium _____ Glob _____
Urea _____ GGT _____
Creatinine _____
eGFR _____ ***Hb*** _____ (Transfusion will not generally occur above 90)
Albumin _____ WBC_____
Calcium _____ Neutrophils _____
Corrected Calcium_____ Platelets _____
ALP _____
ALT _____

We always need a recent U+E including Albumin.

Has this patient had a blood transfusion in the past? Yes / No

If yes when and where _____.

Were there any complication / special requirements recorded? Yes / No

If yes please give details _____

Number of Units required _____

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 ____ /____ / _____