

Referral Form

1. Patient Details

Title: _____ Surname: _____
Forename(s): _____
D.O.B: _____ Age: _____ M/F: _____
NHS Number: _____
Home Address: _____
Postcode: _____
Home Phone: _____
Mobile Phone: _____
Lives Alone: _____ Ethnicity: _____
Religion: _____
Current Location of patient (include ward if inpatient):

2. NOK / Carers Details

Name: _____
Relationship to Patient: _____
Address: _____
Postcode: _____
Home Phone: _____
Mobile Phone: _____

3. Community Health Care Professional Details

GP Name: _____
GP Practice: _____
GP Phone: _____
GP aware of Referral: _____
District Nurse Team: _____
DN Tel No: _____
Social Worker: _____
SW Tel No: _____
Palliative Care Nurse Specialist: _____
Tel No: _____
Other Professionals Involved:

4. Hospital Details

Hospital (1): _____
Consultant (1): _____
Hospital (2): _____
Consultant (2): _____
Clinical Nurse Specialist: _____
Location: _____

5. Service Required (please select as required)

Macmillan Specialist Palliative Care Team

***Please Email EcN-tr.palliativecareteam@nhs.net
or Fax to 01625 661378***

Inpatient Hospital Review: _____
Community Review: _____
Palliative Medicine Consultant Outpatient Clinic

East Cheshire Hospice

***Email ecceg.echospiceipu@nhs.net
or Fax to 01625 665697***

Inpatient Admission
Is this referral for: Action Now
Symptom Management: _____
Optimisation/Rehabilitation: _____
End of Life Care: _____

Sunflower Centre and Hospice Therapies
Email: ecceg.echospicesfc@nhs.net

or Fax to: 01625 666995
Wellbeing assessment: _____
Living Well: _____
Breathlessness programme: _____
Lymphoedema assessment: _____
Art Psychotherapy: _____
Complementary Therapy: _____
Physio outpatient assessment: _____

(for Community physio/OT, please refer separately to
Community Rehab team, fax no. 01625 661856 or
email: ecn-tr.communitytherapieseast@nhs.net)

**Separate referral forms for Blood transfusions, Dementia and MND
Wellbeing can be found on the hospice website
www.eastcheshirehospice.org.uk under 'Professionals'**

Name of patient: _____

DOB: _____

6. Clinical Information about the patient

Primary diagnosis: _____ Date: _____

Sites of Metastases & dates: _____

Treatments received and dates: _____

Significant Past Medical History: _____

Allergies: _____

Infection Risk: _____

Any other relevant information: _____

Patient's understanding of illness: _____

NOK understanding of illness: _____

Resuscitation discussions and outcome:

uDNR-CPR form completed and with patient: _____

Internal cardiac defibrillator (ICD)/ pacemaker insitu: _____

Patient Preferred Place of Care (PPC): _____ Preferred Place of Death (PPD): _____

Continuing Health Care (CHC) Funding Approved: _____

Are the patient and their NOK aware of this referral? Patient: _____ NOK: _____

Has the Patient given consent for health and social care staff involved in their care and treatment to view their health records: _____

Current Situation and reason for referral to Specialist Palliative Care:

Phase of Illness: _____

Please Indicate on Karnofsky Performance Scale the Current Status of the Patient: _____

Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor sign of symptoms of disease	90
Normal activity with effort; some signs or symptoms of disease	80
Cares for self; unable to carry on normal activity or to do active work	70
Able to care for most needs; but requires occasional assistance	60
Considerable assistance and frequent medical care required	50
In bed, more than 50% of the time	40
Almost completely bedfast	30
Totally bedfast and requiring extensive nursing care by professionals and/or family	20
Comatose or barely rousable	10

Referrers Name: _____

Designation: _____ Contact Number: _____ Date: _____

Macmillan Specialist Palliative Care Team (9am-5pm Monday-Friday) Tel 01625 663177, Fax 01625 661378

Bleep via MDGH Switchboard for Urgent Advice 9am-5pm Monday-Friday 1004 (9602 for Lung Cancer Patients)

East Cheshire Hospice 24 hr Advice line 01625 666999