**Specialist Palliative Care Referral Form**

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| **Surname:** | **Title:** | **Sex:** | **Lives alone:** |
| **First name:** | **DOB / age:** | **Lives with:** |
| **Prefers to be called:** | **Interpreter required?** | **Language:** |
| **Address:** | **NHS no:** | **Hospital no:** |
| **Post Code:** | **Telephone:** | **Current location of patient:** |
|  |
| ***Next of kin / main care-giver details*** |
| **Name:** | **Contact details:**  |
| **Relationship:**  |
| **Patient agrees to named person being contacted?**  | **Named person:**  | **Contact details:** |
| Yes / No | **Relationship:** |
|  |  |
| *We request that the patient and the GP are aware of and agree to the referral* |
| **Patient aware of referral?** Yes / No | **GP aware of referral?** Yes / No | **Already known to Sobell?** Yes / No |
| **GP:** | **Consultants:**  |
| **Address:**  |  |
| **District Nurse:** |
|  |
| **Telephone:** | **Key worker:** |
|  |
| **Main diagnosis:** | **Date of diagnosis:**  |
| **Other significant conditions:** |
|  |
| **Reason for referral:**Please give details of uncontrolled symptoms, psycho-social issues, needs of family / carers, and any safety issues). ***Insufficient information may result in a delayed response while further detail is sought***  |
| **Please *√* box if you are including any attached documents** 🞏 |
|  |
| **Referral to *[please √ box]*** |
| **Outpatient Clinic 🞏** | **Day Centre 🞏** | **Community Team 🞏** | **Hospital Team 🞏** | **Inpatient Unit 🞏** |
| Referred patients are contacted for an initial telephone assessment according to priority of need. The subsequent response will depend upon the patient’s needs and service capacity. If a more urgent response is required, please discuss with Specialist Nurse / Dr by phone. A written summary and plan will be sent to the referrer and GP following initial assessment. |
| **Referred by** |
| **Name:**  |
| **Contact details:**  |
| **Signature:** | **Date:** | **Time:** |

Please email completed form to PalliativeCareHub@ouh.nhs.uk