**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](mailto:PalliativeCareHub@ouh.nhs.uk)