

# ADMISSION REQUEST FOR PATIENT KNOWN TO PALLIATIVE CARE SERVICES



## PATIENT DETAILS

Name	Address
DoB:	Tel. No.
GP:	Location of patient if not home:

## DIAGNOSIS

### Reason for Admission (Please Tick)

### Short Summary of Assessed Needs

Symptom Control	<input type="checkbox"/>	
Terminal Care	<input type="checkbox"/>	
Psychological Support	<input type="checkbox"/>	

### URGENCY OF REQUEST

Same Day	<input type="checkbox"/>	Next 48 - 72 Hours	<input type="checkbox"/>	Same Week	<input type="checkbox"/>
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Patient accepting admission?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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( Patient should be made aware that St Wilfrid's is not a long stay unit )

### Transport Requirements

<i>Ambulance:</i>	Stretcher	<input type="checkbox"/>	Chair	<input type="checkbox"/>	<i>Own Transport</i>	<input type="checkbox"/>
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**Additional Information:**  
(Including Oxygen or Equipment needs)

Referred by ..... Designation ..... Date .....

Contact (PRINT Name) ..... Via .....

**FAX this Form and any Supporting Documentation to the Clinical Administrator – Fax No. 01323 430487**