

Specialist Palliative Care Referral Form

St Wilfrid's Hospice, Eastbourne and Community Macmillan team

Send to: Medical Secretary, St Wilfrid's Hospice, 2-4 Mill Gap Road,
Eastbourne, East Sussex, BN21 2HJ

Tel: 01323 644500 Fax: 01323 430487



PLEASE COMPLETE BOTH PAGES OF THIS FORM BEFORE SENDING

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE AND RELEVANT RECENT INVESTIGATIONS WITH THIS FORM (Hospice and Community teams do not have access to NHS computers)

| Patient Details | | | |
|-----------------|--|--|--|
| Surname | Male / Female | Patient consent to Palliative Care involvement | Office use |
| First Name | Lives alone | | |
| Address | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Ethnicity | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Post Code | Tel | Is GP aware of referral? | |
| Marital Status | Mobile Tel | | |
| NHS number | DoB | Age | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Primary diagnosis(es)

Current Location of patient:

Home

Hospital : EDGH / Conquest / BSUH / Other (please state where) _____
Ward _____ Expected date of discharge: ___ / ___ / ___

Other _____

| Next of Kin/Patient Representatives | District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/> | General Practitioner |
|--------------------------------------|--|----------------------|
| Name | Name | Name |
| Address | Based at | Address |
| | Telephone | |
| Telephone | Fax | |
| Relationship to patient | | Postcode |
| Main Carer (if different from above) | Social Services Yes <input type="checkbox"/> No <input type="checkbox"/> | Telephone |
| Name | Name | |
| Telephone | Based at | Fax/email |
| Relationship to patient | Tel Fax | |
| | Continuing care assessment completed: Yes/No | PCT number: |

Reason for Referral (tick all that apply)

Pain/symptom control Emotional/psychological support Social/financial End of life care
 Carer support Other reason e.g. (spiritual, lymphoedema) state: _____

WHICH SERVICE IS SEEN AS MOST APPROPRIATE BY THE REFERRER:
(REFERRALS MAY BE TRIAGED TO MOST APPROPRIATE SERVICE BASED ON NEED AND AVAILABILITY)

Community Macmillan Nurse support Hospice at Home support Day Patient assessment and support
 Out Patient assessment Medical Domiciliary visit Unsure – please triage appropriately
 Admission – please circle reason for admission: Psychological support / symptom control / terminal care

IS REFERRAL URGENT (assess within 2 working days)? Yes No

IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

