HMR 2

901

NHS

Doncaster and Bassetlaw
Health and Social Care Communities

SPECIALIST PALLIATIVE CARE REFERRAL

AFFIX LABEL HERE IF AVAILABLE

NHS Number: .....
District Number: .....
Surname: .....
Forename(s): .....
Address: .....
.....
D.o.B.: .....

PATIENT DETAILS

Marital status: Single Married Widowed Divorced Partner Age: ..... Telephone No.: .....

Religion: ..... Occupation: .....

Ethnic Origin: ..... Is an interpreter required? ☐ Yes ☐ No

Consultant Name: ..... Contact Number: .....

Current location of patient: .....

Smoker ☐ Yes ☐ No

Bariatric ☐ Yes ☐ No If 'Yes', please state weight: .....kgs

Infection ☐ Yes ☐ No If 'Yes', please state: .....

MAIN CARER / NOK

Name: ..... NOK? ☐ Yes ☐ No Relationship: .....

Address: ..... Telephone: .....

Primary Contact: ..... Relationship: .....

Telephone: .....

GP Name: ..... Surgery: ..... Telephone: .....

REASON FOR REFERRAL

☐ Symptom control ☐ Psychological ☐ Spiritual ☐ Social ☐ End of life ☐ Other (specify):

☐ **Patient aware of referral?**
☐ **Carer aware of referral?**
☐ **Medical team/GP aware of the referral?**
☐ **District Nursing Team aware of referral?**

REFER TO

Community Specialist Palliative Care Team:

☐ Doncaster *Tel: 01302 796650* *Fax: 01302 796660*
☐ Bassetlaw *Tel: 01777 274422* *Fax: 01777 709332*

Bassetlaw Hospice:

☐ Inpatient ☐ Day care ☐ Aromatherapy ☐ GPWSI ☐ Carer Support
☐ Bereavement support
Tel: 01777 863270 *Fax: 01777 709917*

St John's Hospice:

☐ Inpatient ☐ Day care ☐ Hospice at Home ☐ Lymphoedema
☐ Counselling ☐ Bereavement Support
Tel: 01302 796666 *Fax: 01302 796660*

Hospital Specialist Palliative Care Team:

☐ Bassetlaw *Tel: 01909 500990 x2981* *Fax: 01909 502945*
☐ Doncaster *Tel: 01302 366666 x3142* *Fax: 01302 647243*

Consultant referral:

☐ OP Clinic ☐ Home visit
☐ Bassetlaw *Tel: 01909 500990 x2981* *Fax: 01909 502945*
☐ Doncaster *Tel: 01302 366666 x4064* *Fax: 01302 647243*

(Please continue over.....)

WPR?
July 2010
WHITE

FURTHER INFORMATION

Referral letter attached? ☐ **Yes** ☐ **No** **GP notes / summary attached?** ☐ **Yes** ☐ **No**

Preferred Place of Care (Specify): ..... *Any Advance Directive?* ☐ *Yes* ☐ *No*

Advanced Decision to Refuse Treatment in place? ☐ *Yes* ☐ *No*

Resuscitation Status (Specify): .....

IF NO ADDITIONAL REFERRAL INFORMATION (letter/summary) PLEASE COMPLETE BELOW

Diagnosis:

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Brief summary:

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Past Medical History:

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Medication list / Allergy: (attach separate sheet if required)

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Further Information:

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Signature: ..... Print Name: ..... Designation: .....

Contact Number: ..... Date: ..... Time: .....