**Patient Referral Form for Specialist Palliative Care** **Private and Confidential**

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St John’s Hospice, Slyne Road, Lancaster, LA2 6ST

Telephone: 01524 382538

**Please complete ALL questions and email to** **MBCCG.SJH.Referrals@nhs.net****.**

**Incomplete forms will cause delay in this referral being processed.**

Charity Number

1157030

**Is the patient aware of & consents to referral?** Y / N **If No, give details:**

**Has the patient consented to electronic record sharing?** Y / N

**Service(s) requested: (please delete if not applicable)** Inpatient Admission Community Services

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| --- | --- |
| **Patient Details:** Name: Gender: Address: Date of Birth: Age: NHS No: Tele No: Home:  Mobile:  Keysafe? Y / N  | GP: Address: Tele No: Current location of patient: Contact No if not at home:Does the patient live alone? Y / NDoes the patient have any dependants? Y / N |
| **First Contact:** Relationship to patient: Address:Postcode: Tele No: Aware of referral?: Y / N | **Main Carer** (if different): Relationship to patient: Address: Postcode:Tele No: Aware of referral?: Y / NHas the patient: Continuing care Y / N A care package Y / N  |
| **Diagnosis**: Date of Diagnosis:  |
| **What are your reasons for referring this patient?****Current Problems** |

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| --- |
| **Medication Issues**Is the patient currently on Oxygen therapy? Y/ N If Yes, please specify the flow rate: **Allergies:** **Relevant Medical History** |
| **Others Professionals involved**: District Nurse: Specialist Nurse: Consultant:  | Social Worker: Physio: Occupational Therapist: Other: |
| **Advance Care Planning:** Is the patient on GSF Register? Y / N Current GSF Status: PPC: PPD: Has the patient got: ‘Just in Case’ drugs? Y / N DNACPR form status:  |
| **Current Risks / Specific Needs** **To patient (e.g Mobility Issues, Infections, Safeguarding, Pressure Ulcers, Wounds, Dietary Requirements, Plus size):****To staff (e.g Access issues, Pets, Challenging Behaviour):**  |
| **Please add any other comments or information which may be helpful:** |
| **Referred by**: Name: Job Title:Organisation:Referral date:Email address: Tele No:  |

**Upon completion, save a copy of this referral form and email it to** **MBCCG.SJH.Referrals@nhs.net**