Specialist Palliative Care Referral Form

South London Palliative and Supportive Care Network

☐ **Ellenor Foundation** (North Bexley) Tel: 020 8310 4100 Fax: 020 8312 2115	☐ **Ellenor Foundation** (South Bexley) Tel: 020 8308 3014 Fax: 020 8308 3168	☐ **Greenwich and Bexley Cottage Hospice** Tel: 020 8312 2244 Fax: 020 8312 4344	☐ **Greenwich Community Palliative Care Team** Tel: 020 8836 5432 Fax: 020 8836 5952
☐ **Guy's and St Thomas'** Guy's Site: Tel: 020 7188 4754 Fax: 020 7188 4748	☐ **Guy's and St Thomas'** St Thomas' Site: Tel: 020 7188 4755 Fax: 020 7188 4720	☐ **K & R Community Palliative Care Team/Princess Alice Hospice** Tel: 01372 468811 Fax: 01372 470937	☐ **Lewisham Macmillan Support Team** Tel: 020 8333 3017 Fax: 020 8333 3270
☐ **St Christopher's Hospice** Tel: 020 8768 4500 Fax: 020 8659 5051	☐ **St Raphael's Hospice** Tel: 020 8335 4575 Fax: 020 8335 4569	☐ **Harris HospisCare** Tel: 01689 825755 Fax: 01689 892999	☐ **Trinity Hospice** Tel: 020 7787 1000 Fax: 020 7787 1067

(PLEASE TICK)

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Patient Details

Surname		Male/Female	Patient consent to Palliative Care involvement ☐ Yes ☐ No	Office use
First Name				
Address				
	Ethnicity			
Post Code	Tel		Is GP aware of referral? ☐ Yes ☐ No	
Marital Status	Mobile Tel			
NHS No	DoB	Age		

Primary diagnosis(es)

Communication

First Language if not English: Communication in English Good Fair Poor (please circle)

Would interpreter be helpful to patient and Palliative Care staff? ☐ Yes ☐ No

Other barriers to communication e.g. hearing loss, confusion

Next of Kin/Patient Representatives	**District Nurse** Yes ☐ No ☐	**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 ☐ No ☐	Telephone
Name	Name	
Telephone	Based at	Fax/email
Relationship to patient	Tel Fax	
	Continuing care assessment completed: Yes/No	

Reason for Referral	**Service required**	**The patient is currently**
☐ Pain/symptom control ☐ Emotional/psychological support ☐ Social/financial ☐ Assessment for hospice admission ☐ Carer support ☐ Other reason e.g. (spiritual, lymphodoema)	☐ Home assessment and support ☐ Hospital assessment ☐ Admission (circle) respite/symptom control / terminal care ☐ Day Care	☐ at home ☐ in hospital (see over) ☐ elsewhere (e.g. Nursing Home) Does patient live alone ☐ Yes ☐ No
	Patient Mobility:	

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

IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

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PATIENT NAME .....

In-Patient details

Hospital		Telephone
Ward	Direct Ward Ext.	Date of discharge (if known)
Consultant (1)		Consultant (2)
Is Palliative Care team involved? ☐ Yes ☐ No		MRSA Status ☐ Positive ☐ Negative ☐ Not known

Brief History of diagnosis(es) and Key treatments

Date	Progression of disease and investigations/treatment	Consultant and hospital

Current problems

1.	4.
2.	5.
3.	6.

Referrer's expectation of current treatment (circle) symptom control / life prolonging / curative

Estimated prognosis (circle) days / weeks / months / years

Past Medical and Psychiatric History	Current Medication/Allergies

Insight

Has patient been told diagnosis? ☐ Yes ☐ No

Is the carer aware of patient's diagnosis? ☐ Yes ☐ No

Does patient discuss the illness freely ☐ Yes ☐ No

Any other comments/information

Please ensure patients are aware information will be held on computer according to the Data Protection Act.

Referrer's signature: Name: (please print)

Job title: Contact number: Bleep no:

Surgery or Hospital: Date:

Comments about this form and/or additional copies, tel: 0207 593 0160, fax: 0207 593 0176