



REFERRAL FORM

Please complete both pages –To complete electronically click on Fill & Sign right of screen

Patient's Name:	
Home Address:	
	Postcode:
Telephone Number:	Mobile Number:
Date of Birth:	Gender:
NHS Number:	Hospital Number:
Current Location:	Lives Alone: Yes <input type="checkbox"/> No <input type="checkbox"/>

Main Carer:	Relationship:
Carer's Address:	
	Postcode:
Telephone Number:	Mobile Number:

Referred for: Outpatient Assessment <input type="checkbox"/> Day Services <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Respite <input type="checkbox"/>
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Diagnosis:

Reason for Referral and Supporting Information:
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Expectations of Admission / Attendance (What has been discussed with patient +/- patients family)
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Has the patient given consent for the referral and for their information (personal and sensitive) being shared with Nightingale House Hospice? Yes <input type="checkbox"/> No <input type="checkbox"/> (If no why? Will need to be completed for referral to progress)

<i>Is Patient and Family aware of:</i>	Patient	Family / Carer
Diagnosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Prognosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Referral	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Patient's resuscitation status: (Please tick) FOR CPR <input type="checkbox"/> NOT FOR CPR <input type="checkbox"/> ADVANCED CARE PLANNING <input type="checkbox"/>
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Prognosis (Please tick)
A – Green – Stable = Months <input type="checkbox"/>
B – Amber – Deteriorating with exacerbations = Weeks <input type="checkbox"/>
C – Red – Last days of life = Days <input type="checkbox"/>
Preferred Place of Death:

Alerts:	
Allergies Yes <input type="checkbox"/> No <input type="checkbox"/>	Infection Risk? Yes <input type="checkbox"/> No <input type="checkbox"/>
ICD's Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes which infection, please give details
M.R.S.A Yes <input type="checkbox"/> No <input type="checkbox"/>	
Oxygen Therapy Yes <input type="checkbox"/> No <input type="checkbox"/> Litres:	Other concerns e.g. Pressure Sores

GP's Name:	
GP's Address:	
Postcode:	
Telephone Number:	Email Address:
District Nurses: Yes <input type="checkbox"/> No <input type="checkbox"/>	District Nursing Team:
Telephone Number:	Email Address:
Macmillan Nurse:	
Consultants:	
Others (e.g. Shooting Star Unit, Dietician):	
Care Package in Place Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Calls:
Name of Agency:	
Any other information:	
Office use only:	
Outcome	

Referral by:	<i>(Please print name)</i> Referred via 24 hour Advice Line: Yes or No
Position:	Telephone Number:
Signed:	Date:

For Office Use
Date and time referral received by:
Date and time first contact:
Date and time of OPA (if applicable):

Please note: The hospice cannot guarantee the security of email correspondence. This could mean that others may read it or it may become lost or deliberately intercepted.