**Nightingale House Hospice Self-Referral Form**

N.B. Please provide as much detail as possible. If urgent advice is needed please contact **01978 316800** (Mon-Fri 9am-5pm) or **01978 316808** (Out of hours)

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| Patient Name: | Enter name | | NHS Number: | Enter NHS no. if known. | Date of Birth: | Enter DOB |
| Home Address: | Enter home address, including post code | | | | | |
| Phone - Home: | Enter home no | | Ethnicity: | Enter ethnicity | | |
| Phone - Mobile: | Enter mobile no | | GP Name: | Enter GP name | | |
| Main Carer /  Next of Kin: | Enter carer / NOK | | GP Surgery: | Enter GP surgery name | | |
| Relationship: | Enter relationship of carer / NOK | | Patient’s email address: | Enter email address | Main Carer / NOK’s preferred contact no: | Enter preferred contact no |
| Patient’s expectation / hopes of referral: | What is the patient’s expectation from the referral? | | | | Patient given information leaflet: | **Y**  **N** |
| Current location of Patient:  Please state in ‘Other’ if patient lives alone. | | Home  WMH  Other Hospital  Hospice  Care Home  Other: Enter other location Ward: Enter ward currently on | | | | |

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| **Please indicate which service(s) are required:**  ***If this is an URGENT referral for admission, please call the numbers above once you have sent the form.*** | Outpatient Services (Nightingale Wellbeing Centre, Outpatient Clinics) |
| InPatient Services (Respite, Symptom Management, EOLC) |

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| **Main Diagnosis:** | What is the patient’s main diagnosis? |
| **Previous treatment and further treatment planned.** E.g. Recent admission(s), radiotherapy, chemotherapy. | What previous treatment/admissions has the patient had and are there any planned treatments? |
| **Reason for referral:** E.g. Pain/sickness management, end of life care, carer going on holiday etc. Include all physical, psychological, social and spiritual issues. | What are the reasons for referral? |
| **Please attach any copies of recent medical correspondence and recent investigations / results that you have.** |

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| **Other relevant medical conditions** |
| What other relevant medical conditions does the patient have? |
| **Current medications and significant recent changes in medication (or send an attachment):** |
| What are the current medications and have there been any significant recent changes in the patient’s medication? |
| **Known allergies / adverse drug reactions:** |
| Enter any known allergies / adverse drug reactions |
| **Any other services supporting the Patient currently:** (e.g. District Nurses, Palliative Care, Cardiology etc.) |
| Enter any other services supporting the patient |

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| **Form completed by:** | **Contact Telephone Number:** |
| Enter name of person completing form | Enter contact number of person completing form |
| **Signed:** | **Date:** |
| Sign here | Enter date form completed |

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| **Patient Flow Team to complete** | **Triage Date** | **Triage Lead** | **Triage actions taken** |
| Triage Date | Enter Triage Lead Name | Enter the actions taken |