**Nightingale House Hospice Self Referral Form**

Please provide as much detail as possible.

Completed forms can be emailed to [nightingalehousereferrals@wales.nhs.uk](mailto:nightingalehousereferrals@wales.nhs.uk).

***Urgent referrals/advice*** please contact **01978 316806** (Mon-Fri 8:30am-4:30pm) or **01978 316800** (out of hours)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | |
| **Patient Name** |  | | | | | | |
| **Date of Birth** |  | | | **NHS Number**  **(if known)** | |  | |
| **Home Address**  **inc. Postcode** |  | | | | | | |
| **Telephone Number** |  | | **Mobile Number** | | |  | |
| **GP Surgery Address & Contact Number** |  | | | | | | |
| **Patient / Family Expectations of Referral** |  | | | | | | |
| **Patient’s Current Location** | Home  Wrexham Maelor  Ward location if known: Ward location  Other hospital, please state: Enter other location | | | | | | |
| **Patient Diagnosis** |  | | | | | | |
| **REFERRAL CONSENT** | | | | | | | |
| **Has the patient consented to the referral being made?** | | | | | Yes  No | | |
| **Has the patient consented to access medical records and to speak to other health care professionals?** | | | | | Yes  No | | |
| **REFERRER CONTACT DETAILS** | | | | | | | |
| **Contact Name** | |  | | **Relationship to Patient** | | |  |
| **Telephone Number** | |  | | **Email Address** | | |  |
| **Date Completed** | |  | | **Signed** | | |  |