PALLIATIVE CARE REFERRAL FORM

Referrals can be made electronically via SystmOne, by phone or email
All urgent referrals should be made by phone

1. Palliative Care Team

Hospital ☐
Community ☐

Tel: 01423 553464

Electronic referrals accepted via SystmOne or email: hdft.palliativecareteam@nhs.net

2. Saint Michael's Hospice

Inpatient unit (GPs and PCT only) ☐
Day Therapy Unit ☐
Palliative Lymphoedema Clinic ☐
Neurological Conditions CNS ☐
Volunteer Visitor Service ☐
Physiotherapy (internal referrals only) ☐
Occupational Therapy (internal referrals only) ☐
Social Work (internal referrals only) ☐
Spiritual/pastoral service (internal referrals only) ☐

Electronic referrals accepted via SystmOne

Routine referrals **Tel: 01423 879687**

Urgent referrals only **Tel: 01423 872658**

Patient Name: Prefers to be called:	NHS no: Hospital no:
Address:	Date of birth: Telephone: Mobile no:
Key code:	Lives alone: Yes / No
Does the patient have communication issues? Yes/No If yes, what are they?	
Current location of Patient: Home ☐ HDFT ☐ Ward _____ Date of admission _____ Other Hospital ☐ Location _____ Care Home ☐ Name _____	
NOK/contact name: Relationship: Telephone number: Is this person Next of Kin? Yes/No Main Carer? Yes/No	GP: Surgery: Tel: Nursing/other care teams involved:
Has patient consented to referral? Yes/No Is relative aware of referral? Yes/No	

Diagnosis, treatment & relevant medical history:

MAIN CONCERNS - REASON FOR REFERRAL (referrals can be for physical, psychological, social and spiritual problems):

Continue on separate sheets ☐

Is a DNACPR in place? Yes / No

Saint Michael's Hospice referrals ONLY:

Detail any supportive interventions e.g. PEG feeding, NIV, oxygen (NB if on oxygen specify L/min)

If patient smokes are they aware that they cannot smoke within the hospice building? YES / NO / N/A

Level of mobility (e.g. aids used):

Access to patient's home (e.g. steps, flat, multi-level etc):

Name of referrer:	Date of referral:
Position:	Contact no:

Date / time referral received:	By:	Signature: