Pendleside Hospice Referral Form (updated Nov 2024)

Email: pendlesidehosp.referrals@nhs.net **Telephone: 01282 440100**

Please complete as fully as possible to avoid delay in referral to the service

Has the patient consented to this referral?	Yes ☐	No ☐
If No, give details:		
Has the patient consented to sharing healthcare information e.g EMIS Sharing?	Yes ☐	No ☐
Has the patient consented to receive appointments via Text Message?	Yes ☐	No ☐

Patient Name		Date of Birth		Age	
Address (incl. postcode)		Marital Status			
		Ethnicity			
		NHS Number (mandatory)			
		Current location of the patient:			
		Does the patient live alone?		Yes ☐	No ☐
Tel. Number		Mobile Number			

Referral Priority: ☐ **Urgent (Ring 01282 440100)** ☐ **Soon** ☐ **Routine**

Referral for (tick all that apply)

INPATIENTS	**HOSPICE AT HOME**	**HEALTH, WELLBEING & REHAB**	**FAMILY SUPPORT**	**MEDICAL**
☐ Assessment ☐ Symptom Control ☐ Last Days of Life ☐ Rehabilitation **Please be aware that the IPU is not a long term place of care*	☐ Hospice at Home ☐ Extended Service (24hr care in last days of life – ring 01282 440106)	☐ Day Services ☐ Complementary Therapy ☐ Physiotherapy ☐ Psychotherapy ☐ Drop In Clinic	☐ Pre-Bereavement Counselling ☐ Post-Bereavement Counselling ☐ Complementary Therapy	☐ Palliative Consultant assessment & review

Clinical Information:

Diagnosis (incl date)	Advance Care Plan in place?	Yes ☐	No ☐
	Clinical Management Plan in place?	Yes ☐	No ☐
Site of Metastases:	DNACPR in place?	Yes ☐	No ☐
	Preferred place for end of life care (PPC/PPD)		

Reason for Referral (including current situation, symptoms and any relevant treatment)

Relevant Past Medical History

Patient Name:	
Current Medication	
Next of Kin (name and address)	**Relationship to patient**
	Telephone no:
	Mobile no:
Main Carer (if different to Next of Kin)	**Relationship to patient**
	Telephone no:
	Mobile no:
Patient's GP	**Telephone no:**
Patient's Consultant	**Telephone no:**
District Nurse	**Telephone no:**
Specialist Palliative Care CNS	**Telephone no:**
Social Worker	**Telephone no:**
Other	**Telephone no:**
Current support provided by professional(s)	
Name of Referrer (Block Capitals)	**Job Title:**
	Organisation:
Inpatient Referrals: Please ensure that the patient/family are aware that the Hospice is not a long term place of care and discharge planning (except end of life care) will be discussed from point of admission onwards	
Telephone No:	**Mobile No:**
Signature:	**Date:**

*****Please email completed referral form to: Pendlesidehosp.referrals@nhs.net*****

Referrals can be made over the phone, if you are unable to email form