RDaSH
leading the way with care

**DONCASTER COMMUNITY
SPECIALIST PALLIATIVE CARE REFERRAL FORM**

AFFIX LABEL HERE IF AVAILABLE

NHS Number: ....
District Number: ....
Surname: ....
Forename(s):..
Address: ....
....
D.o.B.:...

REFERRER DETAILS

Print Name: ....

Last Seen: ....

Sign: ....

Designation: ....

Telephone: ....

Date: ....

REASON FOR REFERRAL

☐ Pain ☐ Symptom Control ☐ Psychological ☐ Spiritual ☐ End of life ☐ Other (specify): ....

....
....

PATIENT DETAILS

Marital status: Single / Married / Widowed / Divorced / Partner

Religion: ....

Ethnic Origin: ....

Consultant Name: ....

Current location of patient: ....

Smoker ☐ Yes ☐ No

Bariatric ☐ Yes ☐ No If 'Yes', please state weight: ....kg

Infection ☐ Yes ☐ No If 'Yes', please state: ....

Falls Risk ☐ Yes ☐ No If 'Yes', date of last fall: ....

Case Manager: ....

Which Community Team: ....

Age: .... Telephone No.: ....

Occupation: ....

Is an interpreter required? ☐ Yes ☐ No

Contact Number: ....

☐ **Patient aware of referral?**

☐ **Carer aware of referral?**

☐ **Medical team/GP aware of the referral?**

☐ **District Nursing Team aware of the referral?**

MAIN CARER / Next of Kin

Name: .... Next of Kin? ☐ Yes ☐ No

Address: ....

Primary Contact: ....

Telephone: ....

GP Name: .... Surgery: .... Telephone: ....

Relationship: ....

Telephone: ....

Relationship: ....

DONCASTER COMMUNITY SPECIALIST PALLIATIVE CARE SERVICES

All referrals to be completed and faxed to:

Telephone: 01302 566666   Fax: 01302 566665

If you know the service you wish to refer to tick the relevant box below:
☐ Community Specialist Palliative Care Team
☐ Inpatient (Hospice)
☐ Consultant Opinion
☐ Day Hospice
☐ Counselling
☐ Bereavement support
☐ MDT discussion

If you are unsure of which service you require, tick here:

☐ St John's Hospice Specialist Palliative Care Services

(Please continue over...)

FURTHER INFORMATION

Patient Name: .... *D.o.B.:* .... *NHS No.:* ....

Referral letter attached? ☐ **Yes** ☐ **No**   **GP notes/summary/discharge letter attached?** ☐ **Yes** ☐ **No**

Preferred Place of Care (Specify): ....

Fast Track package in place ☐ **Yes** ☐ **No**   Do they have pre-emptives available? ☐ **Yes** ☐ **No**

Advanced Decision to Refuse Treatment in place? ☐ **Yes** ☐ **No**   Any Advance Directive? ☐ **Yes** ☐ **No**

DNACPR Status (Specify): ....

PLEASE COMPLETE BELOW: ADD ADDITIONAL INFORMATION (Letter/summary if available).

Diagnosis: ....

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....

Summary: *(Must include past medical history, details of referral, current medications, what has been tried, any allergies, attach separate sheet if necessary)*

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What would you like from Specialist Palliative Care?

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Is patient already known to a Specialist palliative care team or a Specialist nurse / service e.g. Lung CNS? ☐ **Yes** ☐ **No**

If yes, who: ....

When where they last seen? ....

Any future appointments: ....