

Specialist Palliative Care Referral Form

For use by the Individual Organisation Only
DATE:

North Herts Palliative Care Providers

Garden House Hospice
Tel: 01462 679540
Fax: 01462 483251

**Lister Hospital
Palliative Care Team**
Tel: 01438 781035
Fax: 01438 284632.

Marie Curie
Via District Nurse

Garden House Hospice at Home
Tel: 01462 675758

East & North Herts Community Macmillan Team
(covering N.Herts, Stevenage & Royston)
Tel: 01462 427034 Fax: 01462 427032

East Herts Palliative Care Providers

Isabel Hospice **COMM TEAM**
Tel: 01707 382500 Fax: 01707 382599

IPU & Hospice at Home Tel:
Fax: 01707 326139 01707 382500

QE2 Hospital
Palliative Care Team
Tel: 01707 365327 Fax 01707 369001

PLEASE PHONE FOR URGENT REFERRAL OR IMMEDIATE ADVICE

Essential Patient Details			
Surname:	Age:	DoB:	Patient consents to palliative care referral Yes No
First Name:	Marital Status:	Occupation:	
Male /Female	Ethnicity:	Religion:	Does the Patient Live Alone? Yes No
Address:			PRIMARY DIAGNOSIS
Post Code:			
Tel:			Has resus status been discussed? Yes No Unknown
Mobile Tel: Work Tel:			
NHS number:			Other barriers to communication
Hospital No:			
Ethnicity First Language if not English Interpreter needed			
NEXT of KIN		Address:	
Relationship to patient:		Tel:	
Main Carer (if different from above)		Address:	
Relationship to Patient:		Tel:	
District Nurse Yes No	Name:	Based at:	
Tel:	Fax:		
GP	Name:	Address:	
Tel:	Fax:		
Aware of Referral Yes No	Name:	Continuing care assessment completed: Yes No	
Tel:	Based at:	By Whom:	
Fax/email:	Tel:	Based at:	
Other Professionals:	Tel:		
Name:	Job Title:	Fax/email:	
Identified KEY WORKER?			Based at:
What does the patient know of illness and prognosis?			
Does the patient discuss the illness freely? Yes No Is the carer aware of the diagnosis? Yes No			

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE & SINGLE ASSESSMENT PAPERWORK IF AVAILABLE WITH THIS FORM

