St Ann's Hospice

CONFIDENTIAL REFERRAL FORM

For information and guidance on referring a patient, please see our Referral Handbook

PATIENT DETAILS:	**NEXT OF KIN DETAILS:**	**MAIN CARER DETAILS: (if different)**
Surname		
First name	Name	Name .....
Known as	Relationship	Relationship .....
Date of birth	Address	Address .....
Sex	.....	.....
Address	.....	.....
.....	Postcode	Postcode .....
Postcode	Contact no	Contact no .....
Contact no/mobile		
NHS number		

GENERAL PRACTITIONER:	**Involvement of other agencies and contact details:**	
Name	**Consultant(s)**	
Address	Name	Contact no .....
.....	Hospital	
.....	Name	Contact no .....
Postcode	Hospital	
Contact no	**District Nurse**	
GP aware of referral: YES ☐ NO ☐	Name	Contact no .....
	Specialist Nurse/Macmillan Nurse	
	Name	Contact no .....
	Social Worker	
	Name	Contact no .....

Please identify any other professional involvement in patient's care: e.g. OT/Physio/Dietitian

Name ..... Profession ..... Contact no .....

Name ..... Profession ..... Contact no .....

SERVICE REQUIRED:	**OUTPATIENTS**	**COMMUNITY SUPPORT**
INPATIENTS	Medical Outpatients ☐	(Salford Only)
Admission required ☐	Day Therapy ☐	Specialist Palliative Care Nurse ☐
End of life care ☐	Lymphoedema Management ☐	Response Time:
Symptom control ☐	Supportive Outpatients ☐	Urgent referral- Response in 2 hrs ☐
		Non urgent referral ☐
		(Salford & Trafford Only):
		Hospice @ Home ☐

Reason for referral .....

Details of Diagnosis (including severity and date): .....

Co-existing Medical Conditions (including Mental Health Conditions): .....

Current Symptoms requiring specialist input: .....

.....

Medication History: .....

.....

Does the person have the capacity to consent to the referral as per the Mental Capacity Act 2005 YES ☐ NO ☐
If not, please provide capacity assessment and best interest documentation. Also provide any information regarding any DoLs in place (please attach to referral)

Please confirm if the patient has:

NG Tube/PEG/TPN	YES ☐	NO ☐	(Please specify if has feeds) .....
Tracheostomy tube	YES ☐	NO ☐	Size .....
Oxygen	YES ☐	NO ☐	Flow rate .....
Pressure sore	YES ☐	NO ☐	Details .....

Is the patient being treated for/ had a history of: Acquired infections MRSA/C. Diff/VRE/CPE YES ☐ NO ☐

ADDITIONAL PATIENT INFORMATION:

Interpreter required .....
Visual impairment .....
Hearing impairment .....
Dietetic requirements .....
Moving & handling requirements .....
Bariatric requirements .....
Home access & mobility requirements .....
.....
.....

Social Circumstances: i.e. home situation, carer responsibilities, support network, agencies involved, financial/legal issues

.....
.....
.....

Any other relevant information: i.e. communication issues, importance of religion, fears etc. Has Continuing Healthcare been applied for? .....
.....
.....

Does the patient smoke? YES ☐ NO ☐

If the patient is unable or unwilling to comply with the smoking conditions referred to in the Referral Handbook, they should not be referred to the hospice, or may wish to decline referral.

ADVANCE CARE PLANNING:

Preferred Place of Care discussed	YES ☐	NO ☐	Details .....
Preferred Place of Death discussed	YES ☐	NO ☐	Details .....
LPA Health & Welfare	YES ☐	NO ☐	Details .....
LPA for Finance	YES ☐	NO ☐	Details .....
Advanced Care Planning	YES ☐	NO ☐	Details .....
Palliative Care Register/GSF	YES ☐	NO ☐	Details .....
EpaCCs/CCS	YES ☐	NO ☐	Details .....
uDNACPR	YES ☐	NO ☐	Details .....

REFERRER DETAILS:

Name .....
Designation .....
Address/dept .....
.....
Postcode .....
Contact no

REFERRING HOSPITAL DETAILS:

Hospital ..... Ward .....
Consultant .....
Discharge date .....
Contact no .....
Current location of patient .....
.....

PATIENT AUTHORITY FOR CONTACT Please tick this box if the patient does NOT consent to receiving SMS text messages from the hospice with news about services and/or appointment reminders ☐

Signature of referrer :
PRINTED NAME:
Contact number :
Date of referral:
Has the patient's Medical Lead been informed of referral Yes ☐ No ☐

Please return this form to the relevant St Ann's site, using the following details:

Heald Green:
St Ann's Hospice Admissions Office,
St Ann's Road North,
Heald Green, Cheadle, SK8 3SZ
Phone: 0161 498 3608
Fax: 0161 498 9640
Email: nehgm.admissions-hg@nhs.net

Little Hulton:
St Ann's Hospice Admissions Office,
Meadowsweet Lane, Off Peel Lane,
Little Hulton, Worsley, M28 0FE
Phone: 0161 702 5408
Fax: 0161 790 0186
Email: stan.admissions-lh@nhs.net

Neil Cliffe Centre:
Neil Cliffe Centre, Wythenshawe Hospital,
Southmoor Road, Wythenshawe,
Manchester, M23 9LT
Phone: 0161 291 2912
Fax: 0161 291 2968
Email: nehgm.neilcliffe@nhs.net

Admissions Offices are open Mon - Fri 8am - 4pm, excluding bank holidays. Out of hours please contact the main hospice switchboards and ask to speak to the Nurse in Charge: Heald Green 0161 437 8136, or Little Hulton 0161 702 8181.

Additional Information