

PATIENT DETAILS: Surname First name Known as Date of birth Sex Address Postcode Contact no/mobile NHS number	NEXT OF KIN DETAILS: Name Relationship Address Postcode Contact no	MAIN CARER DETAILS: (if different) Name Relationship Address Postcode Contact no
GENERAL PRACTITIONER: Name Address Postcode Contact no GP aware of referral: YES <input type="checkbox"/> NO <input type="checkbox"/>	Involvement of other agencies and contact details: Consultant(s) Name Contact no Hospital Name Contact no Hospital District Nurse 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: INPATIENTS Admission required <input type="checkbox"/> End of life care <input type="checkbox"/> Symptom control <input type="checkbox"/>	OUTPATIENTS Medical Outpatients <input type="checkbox"/> Day Therapy <input type="checkbox"/> Lymphoedema Management <input type="checkbox"/> Supportive Outpatients <input type="checkbox"/>	COMMUNITY SUPPORT (Salford Only) Specialist Palliative Care Nurse <input type="checkbox"/> Response Time: Urgent referral-Response in 2 hrs <input type="checkbox"/> Non urgent referral <input type="checkbox"/> (Salford & Trafford Only): Hospice @ Home <input type="checkbox"/>
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

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

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

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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:

HospitalWard

Consultant

Discharge date

Contact no

Current location of patient

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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: NeilCliffeCentre.sah@nhs.net
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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

A large rectangular area with a black border, containing numerous horizontal dotted lines for writing.