

<b>PATIENT DETAILS:</b> Surname ..... First name ..... Known as ..... Date of birth ..... Sex ..... Address ..... ..... Postcode ..... Contact no/mobile ..... NHS number .....	<b>NEXT OF KIN DETAILS:</b> Name ..... Relationship ..... Address ..... ..... Postcode ..... Contact no .....	<b>MAIN CARER DETAILS: (if different)</b> Name ..... Relationship ..... Address ..... ..... Postcode ..... Contact no .....
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<b>GENERAL PRACTITIONER:</b> Name ..... Address ..... ..... Postcode ..... Contact no ..... GP aware of referral:    YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>Involvement of other agencies and contact details:</b> <b>Consultant(s)</b> Name .....    Contact no ..... Hospital ..... Name .....    Contact no ..... Hospital ..... <b>District Nurse</b> Name .....    Contact no ..... <b>Specialist Nurse/Macmillan Nurse</b> Name .....    Contact no ..... <b>Social Worker</b> Name .....    Contact no .....
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**Please identify any other professional involvement in patient's care: e.g. OT/Physio/Dietitian**

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

<b>SERVICE REQUIRED:</b> <b>INPATIENTS</b> Admission required <input type="checkbox"/> End of life care <input type="checkbox"/> Symptom control <input type="checkbox"/>	<b>OUTPATIENTS</b> Medical Outpatients <input type="checkbox"/> The Being You Centre (including Supportive Outpatients) <input type="checkbox"/> Lymphoedema Management <input type="checkbox"/> Neil Cliffe Centre <input type="checkbox"/>	<b>COMMUNITY SPECIALIST PALLIATIVE CARE TEAM (Salford Only)</b> Specialist Palliative Care Nurse <input type="checkbox"/> <b>Response Time:</b> Urgent referral - Response in 2 hrs <input type="checkbox"/> Non urgent referral <input type="checkbox"/> <b>Hospice @ Home (Salford &amp; Trafford Only):</b> <input type="checkbox"/>
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**Reason for referral. Please see referral criteria on website. Please continue on page 3 if needed.**

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

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

**Current Symptoms requiring specialist input:** .....

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**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) Your referral could be delayed if this is not completed.**

**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 .....

Palliative Care Register/GSF YES  NO  Details .....

EpaCCs/CCS YES  NO  Details .....

uDNACPR YES  NO  Details .....

**REFERRER DETAILS:**

Name .....

Designation .....

Address .....

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Postcode .....

Contact no .....

**REFERRING HOSPITAL DETAILS:**

Hospital .....Ward .....

Consultant .....

Discharge date .....

Contact no .....

Current location of patient .....

(e.g at home, hospital)

**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  
**Email:** NeilCliffeCentre.sah@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

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