Sheffield Specialist Palliative Care Referral Form

PATIENT Surname:	First name(s):
Date of birth: Age:	NHS No:
Address:	Hospital No:
	Marital/civil status:
	Ethnic origin:
Telephone:	Religion:
Allergies:	Occupation:
Is an interpreter required? Yes ☐ No ☐	If yes, which language?
Current location of patient:	Current/previous infection status:
Is patient aware of referral? Yes ☐ No ☐	Is consultant/GP aware of referral? Yes ☐ No ☐

1st CONTACT Name:	**2ND CONTACT** Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person the next of kin? Yes ☐ No ☐	Is this person the next of kin? Yes ☐ No ☐

GP Name:	**CONSULTANTS** Name & location:
Address:	
Telephone:	

TYPE OF REFERRAL (Please tick)	☐ Urgent ☐ Routine
Community Palliative Care Team	☐ FAX to 235 1321 or phone 236 9911
NGH Hospital Support Team or Clinic	☐ FAX to 27 **14289** or phone 22 **66770**
RHH/WPH Hospital Support Team or Clinic	☐ FAX to 22 **65745** or phone 22 **65260**
Intensive Home Nursing or VIP Service	☐ FAX to 27 **16026** or phone 27 **16010**
Sheffield Macmillan Unit: Admission	☐ FAX to 27 **14289** or phone 22 **66770**
St Luke's Hospice: Admission	☐ FAX to 235 1321 or phone 236 9911
St Luke's Hospice: Day hospice	☐ FAX to 235 1321 or phone 236 9911

DIAGNOSIS & PAST MEDICAL HISTORY Include dates:
Is the patient aware of their main diagnosis? Yes ☐ No ☐

REFERRED BY:	Post	Contact no:
Date of referral:	Total no. of pages including this one:	

PRC 026/06
PD3665a

Produced June 2006 - Amended February 2010
Review by January 2011

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PATIENT Name:	Date of birth:	NHS No:

REASON FOR REFERRAL (Please tick all that apply):

Pain ☐ Symptom control ☐ Psychological ☐ Spiritual ☐ Social ☐ End of life care ☐

Assessment for Palliative Care admission ☐ Other ☐ Please specify:

SUMMARY OF MAIN CONCERNS INCLUDING CURRENT INTERVENTIONS:

MEDICATION HISTORY:

SOCIAL HISTORY:

OUTCOME & SUBSEQUENT EPISODES (for office use only):

Referred on for:	By:	Current location of patient:	Date

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