

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 <input type="checkbox"/> No <input type="checkbox"/>		If yes, which language?	
Current location of patient:		Current/previous infection status:	
Is patient aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>		Is consultant/GP aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	

1st CONTACT Name:	2ND CONTACT Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person the next of kin? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is this person the next of kin? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

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

DIAGNOSIS & PAST MEDICAL HISTORY Include dates:	
Is the patient aware of their main diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

The information in this fax is confidential and for the addressee only. It may contain legally privileged information. The contents are not to be disclosed to anyone other than the addressee. If you are not the intended recipient you must preserve this confidentiality and should please advise the sender immediately by telephone and return the original fax to us, by post, without copying, distributing it or taking action relying on the contents of the information as this may be unlawful.

PAGE 1 of 2 Please ensure both pages are completed

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PATIENT Name:	Date of birth:	NHS No:
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REASON FOR REFERRAL (Please tick all that apply):					
Pain <input type="checkbox"/>	Symptom control <input type="checkbox"/>	Psychological <input type="checkbox"/>	Spiritual <input type="checkbox"/>	Social <input type="checkbox"/>	End of life care <input type="checkbox"/>
Assessment for Palliative Care admission <input type="checkbox"/> Other <input type="checkbox"/> 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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