ESSEX SUPPORTIVE AND PALLIATIVE REFERRAL FORM

For all urgent referrals please telephone the relevant number below and fax later

South West Essex Services		**South Essex Services**	
ST Luke's Hospice	Fax No: 01268 282483 Tel No:	Fairhaven's Hospice	Fax No: 01702 437009 Tel No:
Basildon Hospital Palliative Care Team	Fax No: 01268 593326 Tel No:	Southend Hospital Palliative Care Team	Fax No: 01702 221413 Tel No:
Community Macmillan Palliative Care Team: Basildon, Thurrock, Billericay, Wickford areas	Fax No: 01268 448522 Tel No:	Community Macmillan Palliative Care Team: Southend, Benfleet, Rochford, Canvey Island areas	Fax No: 01702 433347 Tel No:
Hospice at Home Basildon & Thurrock	Fax No: 01268 530552 Tel No: 07739890140	Hospice at Home Southend Urgent referrals PHONE	Fax No: 01702 339365 Tel No: 07850 613445
North Essex Services		**Mid Essex Services**	
St.Helena Hospice	Fax No: 01206 843294 Tel No; 01206 845566	Farleigh Hospice	Fax No: 01245 457333
Colchester Hospital Palliative Care Team	Fax 01206 744511. Tel No: 01206 744018	Broomfield Hospital Palliative Care Team	
Community Macmillan Palliative Care Team based at St. Helena Hospice	Fax No: 01206 843294 Tel No: 01206 845566	Community Macmillan Palliative Care Team based at Farleigh Hospice	Fax No: 01245 514405
Hospice at Home Colchester and Tendring	Fax & tel no: 01206 751468		

WHERE CAN PATIENT BE CONTACTED?

SURNAME:-

FIRSTNAME:

PREFERRED NAME:-

NHS NO:-

Male: ☐ **Female:** ☐

ADDRESS:

POSTCODE:

DATE OF BIRTH:

TELEPHONE No: HOME:

WORK:

MOBILE:

OCCUPATION:

NOMINATED PERSON (nok):

Relationship:

Aware of diagnosis: **Y** ☐ **N** ☐

Address (If different to pt)

Telephone No: Home:

Work:

Mobile:

MAIN CARER (If not N.O.K.)

Relationship: Tel:

Address (if different to pt)

ETHNIC GROUP:

PREFERRED LANGUAGE:

RELIGION/BELIEF SYSTEM:

MARITAL STATUS:

Married: ☐ Widowed: ☐ Single: ☐

Divorced: ☐ Co-Habiting ☐ Separated: ☐

PRIMARY DIAGNOSIS:

DATE of DIAGNOSIS:

Sites of any Secondary Spread:

CURRENT TREATMENT:

GENERAL PRACTITIONER:

SURGERY DETAILS:

TELEPHONE NO:

AWARE OF REFERRAL: **Y** ☐ **N** ☐

PATIENT AWARE of DIAGNOSIS: **Y** ☐ **N** ☐

PATIENT AWARE OF REFERRAL: **Y** ☐ **N** ☐

IF NOT WHY NOT?

OTHER MEDICAL CONDITIONS:

LIVES ALONE? **Y** ☐ **N** ☐

PATIENT NAME: **DATE of BIRTH:**

NHS NO:

OTHER SERVICES INVOLVED:	**Patient Known to Service**	**Referred**	**Date**
DISTRICT NURSE Name: Base & Tel No:	☐	☐	
SOCIAL WORKER: Name: Base & Tel No:	☐	☐	
SITE SPECIFIC CLINICAL NURSE SPECIALIST: Name: Base & Tel No:	☐	☐	
OCCUPATIONAL THERAPIST: Name: Base & Tel No:	☐	☐	
HOSPICE AT HOME:	☐	☐	

HOSPICE AT HOME REFERRALS HEALTH & SAFETY ISSUES

Access to Home:

Equipment in Use:

Manual Handling Issues: Tick ✔

- Mobile: ☐
- Bed / Chair Bound: ☐
- Weight Bearing: ☐
- Not Weight Bearing: ☐
- Environmental Risks: ☐
- Risk of Falls: ☐

CONSULTANTS INVOLVED: (not initials) **SPECIALITY:** **HOSPITAL:** **HOSPITAL NUMBER:**

ALERT: INFECTION RISK MRSA / C DIFF ☐ DRUG ALLERGY ☐ CONFIDENTIALITY ISSUE ☐ SOCIAL/HOME ISSUE ☐ MENTAL CAPACITY ☐ CHILDREN/ POVA ☐ OTHER ☐

Please Give Details:

Preferred Place of Care	**HOME**	**NURSING HOME**	**HOSPICE**	**HOSPITAL**	**PREFERRED PLACE OF CARE DOCUMENT**
PATIENT					**YES:**
FAMILY					**NO:**

REASON for REFERRAL		**Please expand on reason for referral (see Criteria for referral if needed)**
PSYCHSOCIAL SUPPORT	☐	
SYMPTOM CONTROL	☐	
RESPITE CARE	☐	
TERMINAL CARE	☐	
ASSESSMENT	☐	
BEREAVEMENT	☐	
SPIRITUAL	☐	
REHABILITATION	☐	

DETAILS OF REFERRAL to SPECIALIST PALLIATIVE CARE SERVICES (SPC)

NAME OF REFERRER: DESIGNATION:

CONTACT DETAILS OF REFERRER:

REFERRAL DATE:

PATIENT & CARER AWARE OF REFERRAL & AGREEABLE TO TRANSFER OF INFORMATION: **YES** ☐ **NO** ☐