

Office Use only	Hospice Number.....
Date of receipt.....	Date Referral Form Reviewed.....
Date 1 st Contact.....	First Visitby Home Care /Dr

REFERRAL FOR PALLIATIVE CARE

-Medical in Confidence



REFERRAL TO:

Main Service Requested	tick
Macmillan Homecare	<input type="checkbox"/>
Admission	<input type="checkbox"/>
Day Care	<input type="checkbox"/>
Doctor assessment	<input type="checkbox"/>

Dr Graeme Giles Dr Fiona Downs Strathcarron Hospice, Randolph Hill, Denny, FK6 5HJ SAFE FAX 01324 826119
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URGENCY OF REFERRAL

Routine <input type="checkbox"/> Soon <input type="checkbox"/> Urgent <input type="checkbox"/> * tick one

*If urgent please phone to discuss with medical staff

PATIENT DETAILS:

<i>Name</i>	<i>Date of birth</i>	<i>CHI No</i>
<i>Address with postcode</i>	<i>Current location if different</i>	
<i>Phone no</i>	<i>Phone no</i>	

REFERRING PRACTITIONER DETAILS:

<i>Name</i>	<i>GP Practice name & address</i>
<i>Tel:</i>	
<i>Fax:</i>	

Consultants or Specialist services currently involved

eg Stoma CNS Area Rehab give contact number if unusual

<i>Name</i>	<i>Service/Speciality</i>	<i>Location</i>

Name:

CHI number:

Date of birth:

DIAGNOSIS including histology, site and dates

HISTORY OF THIS ILLNESS from diagnosis.

Please include radiological/pathological results & treatment given.

DATE WHEN BLOODS LAST TAKEN

CURRENT CARE ISSUES physical signs symptoms

CURRENT family social psychological & spiritual issues

REASON FOR REFERRAL and EXPECTATION OF OUTCOME

eg Symptom control, respite, terminal care, rehabilitation

Name:

CHI number:

Date of birth:

PAST MEDICAL HISTORY

CURRENT AND RECENT MEDICATION

CLINICAL WARNINGS (eg allergies blood-borne viruses)

ADDITIONAL RELEVANT INFORMATION

Smoking

Alcohol

Yours sincerely

Date