Referral Form

PLEASE USE BLOCK CAPITALS AND BLACK INK – THANK YOU

<table>
<tr><th colspan="4">WARRINGTON AND HALTON: REFERRAL FOR SPECIALIST PALLIATIVE CARE SERVICES</th></tr>
<tr><td colspan="2">Patient Details</td><td colspan="2" rowspan="2">Relevant Treatments:</td></tr>
<tr><td colspan="2">NHS No:</td></tr>
<tr><td>Title:</td><td>Gender: M / F</td><td colspan="2" rowspan="5"></td></tr>
<tr><td colspan="2">Forename:</td></tr>
<tr><td colspan="2">Surname:</td></tr>
<tr><td>Age:</td><td>DOB:</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td>Post Code:</td><td>Tel:</td><td colspan="2" rowspan="3">Any Known Allergies:</td></tr>
<tr><td>Ethnicity:</td><td>Religion:</td></tr>
<tr><td>Marital Status:</td><td>Smoker? Y / N</td></tr>
<tr><td colspan="2">History of Illness</td><td>ICD in situ:
Y / N</td><td>Deactivated:
Y / N</td><td>Pacemaker in situ:
Y / N</td></tr>
<tr><td colspan="2" rowspan="2">Diagnosis incl. known metastases:</td><td colspan="3">Next of Kin Details</td></tr>
<tr><td colspan="3" rowspan="3">Name:
Relationship to patient:
Address:</td></tr>
<tr><td colspan="2">Patient aware of diagnosis? Y / N</td></tr>
<tr><td colspan="2">Date of diagnosis:</td><td colspan="2">Post Code:</td><td>Tel:</td></tr>
<tr><td colspan="2" rowspan="2">Other medical conditions:</td><td colspan="3">Is the patient living alone? Y / N</td></tr>
<tr><td colspan="3">Where is the patient presently?</td></tr>
<tr><td colspan="2">Current Medication (incl. dose and frequency)</td><td colspan="3">Involved Professional Details</td></tr>
<tr><td colspan="2" rowspan="15"></td><td colspan="3">GP Name:</td></tr>
<tr><td colspan="3">GP Surgery:</td></tr>
<tr><td colspan="2">GP Tel:</td><td>GP Fax:</td></tr>
<tr><td colspan="3">District Nurse:</td></tr>
<tr><td colspan="2">DN Tel:</td><td>DN Fax:</td></tr>
<tr><td colspan="3">Community Specialist Nurse:</td></tr>
<tr><td colspan="2">SN Tel:</td><td>SN Fax:</td></tr>
<tr><td colspan="3">Hospital Consultant:</td></tr>
<tr><td colspan="3">Hospital Consultant:</td></tr>
<tr><td colspan="3">Hospital Specialist Nurse:</td></tr>
<tr><td colspan="3">Referral Information</td></tr>
<tr><td colspan="3">Is GP aware of referral? Y / N</td></tr>
<tr><td colspan="3">Is Patient aware of referral? Y / N</td></tr>
<tr><td colspan="3">Date last seen by referrer:</td></tr>
</table>

Patient Name:	**NHS No:**

Reason for referral: Please complete with **all** relevant details as incomplete forms will result in processing delay that will impact on patient care.

Current Problems:

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Expectations / Aims of Specialist Palliative Care Involvement:

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PLEASE INDICATE SERVICE REQUIRED WITH ✓ AND FAX/EMAIL TO APPROPRIATE NUMBER (below)

Hospital Outpatient Clinic (Halton) ATTACH LETTER:		☐	**01925 662347**
Hospital Outpatient Clinic (Warrington) ATTACH LETTER:		☐	**01925 662347**
St Rocco's Hospice Outpatient Clinic:		☐	**01925 630690**
Halton Outpatient Clinic:		☐	**bchft.haltonspct@nhs.net**
Warrington Community Palliative Care team:		☐	**01925 579202**
Halton Community Palliative Care Team:		☐	**bchft.haltonspct@nhs.net**
Warrington & Halton Hospitals Palliative Care Team:		☐	**01925 662347**
St Rocco's Hospice:	- **Inpatient**	☐	**01925 630690**
	- **Day Therapy Services**	☐	
	- **Family Support Team**	☐	
Halton Haven Hospice:	- **Inpatient**	☐	**haltonhavenhospice.inpatients@nhs.net**
	- **Day Therapy Services**	☐	
	- **Family Support Team**	☐	
For Information Only (to a team above):		☐	**Choose from above**

Referrer Details

Printed Name:	Designation:	
Phone Number:	Signature:	Date: