|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT/SERVICE USER DETAILS** | | | | | | | | | | | | | | | | | | |
| Surname: | | | | | | | | | | | Date of birth: | | | | | | | |
| First Name: | | | | | | | | | | | Age: | | | | | | | |
| Preferred Name: | | | | | | | | | | | Ethnicity | | | | | | | |
| Address:  Post Code: | | | | | | | | | | | Home Tel No: | | |  | | | | |
| Work Tel No | | |  | | | | |
| Mobile Tel No: | | |  | | | | |
| NHS No: | |  | | | | | | | | | Marital status: | | |  | | | | |
| **Consent -** Has the patient givenconsent for this referral? | | | | | | Yes | | No | | Has the patient given consent to share medical records? | | | | | | | Yes | No |
| *Please Note no referral will be processed without Valid Patient Consent. In the absence of Patient capacity to give consent a valid MCA2 best interest decision must be used.* | | | | | | | | | | | | | | | | | | |
| **Communication**  Does the patient/service user have any sensory needs or need any communication adjustments (if yes please specify) | | | | | | | | | | | | | | | | | Yes | No |
| **PATIENT INSIGHT:** | | | | | | | | | | | | | | | | | | |
| Is the patient aware of their diagnosis? | | | | | | | | | | | | | | | Yes | | | No |
| Is the patient aware of their prognosis? | | | | | | | | | | | | | | | Yes | | | No |
| Does the patient have a DNACPR in place? | | | | | | | | | | | | | | | Yes | | | No |
| Preferred Place of Care *(please state)* | | | | | | | | | | | | | | |  | | |  |
| Preferred Place of Death *(please state)* | | | | | | | | | | | | | | |  | | |  |
| **HISTORY OF PRIMARY DIAGNOSIS (ES) AND TREATMENTS:**  e.g. progression of disease, investigations and current focus of treatment | | | | | | | | | | | | | | | | | | |
| Date: |  | | | | | | | | | | | | | | | Consultant and Hospital | | |
|  |  | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | |  | | |
| **RELEVANT PAST MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Pacemaker? | | | Yes | No | **Drug Sensitivities and Allergies:** | | | | | | | ***Please give details:*** | | | | | | |
| ICD? | | | Yes | No |
| **REASONS FOR REFERRAL** *(please tick below)* | | | | | | | | | | **LOCATION REQUESTED** *(please tick below)* | | | | | | | | |
| End of Life Support | | | | | | |  | | | Patients usual place of residence | | | | | | | |  |
| Pain/Symptom Control | | | | | | |  | | | Hospital assessment | | | | | | | |  |
| Palliative Rehabilitation | | | | | | |  | | | Hospice Inpatient Admission | | | | | | | |  |
| Respite | | | | | | |  | | | Day Services | | | | | | | |  |
| Carer/Family support | | | | | | |  | | | Other *(please state)* | | | | | | | | |
| Bereavement Support | | | | | | |  | | | **GSF RAG** | | | | | | | | |
| Other reason (*please state)* | | | | | | |  | | | Red\*(rapid deterioration, death expected hrs/days) \*See Below | | | | | | | |  |
|  | | | | | | |  | | | Amber (unresolved symptoms/issues) | | | | | | | |  |
|  | | | | | | |  | | | Green (symptoms stable, routine monitoring required) | | | | | | | |  |
| **\*All Red referrals should be followed up with a telephone call to the advice line and discussion with the Triage or Advice Line Nurse to establish presenting urgent needs.** | | | | | | | | | | | | | | | | | | |
| **CURRENT PROBLEMS NECESSITATING REFERRAL** | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | Briefly explain issues: | | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| **NOK/Patient Representative** | | | | | | | | | **Other Patient Representative** | | | | | | | | | |
| Name: | | | | | | | | | Name: | | | | | | | | | |
| Relationship to patient: | | | | | | | | | Relationship to Patient: | | | | | | | | | |
| Address: | | | | | | | | | Address: | | | | | | | | | |
| Home Tel No: | | | | | | | | | Home Tel No | | | | | | | | | |
| Mobile Tel No | | | | | | | | | Mobile Tel No | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |
| **General Practitioner** | | | | | | | | | **Social Services** | | | | | | | | | |
| GP’s Name: <GP Name> | | | | | | | | | Allocated Social Workers Name: | | | | | | | | | |
| Practice Address:  <GP Details>  <GP Details> | | | | | | | | | Based at: | | | | | | | | | |
| Practice Tel No: <GP Details> | | | | | | | | | Tel No: | | | | | | | | | |
| GP Aware of Referral: | | | | | Yes | | No | |  | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | |
| **Referred by:**  ***(please print)*** | | | | | | | | | | | | | **Role:** | | | | | |
| **Contact Telephone No:** | | | | | | | | | | | | | **Date: <Today's date>** | | | | | |

**Please complete in full and email to the** [**contactteam.fh@nhs.net**](mailto:contactteam.fh@nhs.net)

**For all urgent referrals please telephone 01245 455478 to discuss, followed by written referral**