|  |
| --- |
| **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**

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