PALLIATIVE CARE REFERRAL FORM

Ardgowan Hospice

12 Nelson Street, Greenock, PA15 1TS
Tel: 01475 726830 Fax: 01475 558859 E-mail form to:-
Clinical Services Support Dept. GG-UHB.ardhosp@nhs.net

PATIENT LOCATION: **IRH Ward** ☐ **At Home** ☐ **Other** ☐

Patient Details (Attach patient label here)		Sex ..... M / F	CHI No.	
Name:		Marital status... M / S / W / D	Date of Birth	
Address:		Lives alone ☐ or Lives with.....	Hospital No	
			Occupation	
Post Code:		Ethnic Origin.....	Date 1st Contact	
Tel No:		Religion.....	Date 1st Seen	

Next of Kin/Main Carer			
Name:		Relationship:	
Address:		Telephone Home:	
		Work:	
		Mobile:	

Current Support			
Family only:		Hospital Nurse Specialist:	
Carer/Home Help:		District Nurse:	

Professional Contacts			
Consultant One:		G.P. Name:	
Hospital:		G.P. Tel No:	
Consultant Two:		Is GP aware of referral?	Yes ☐ No ☐
Hospital:		Known to Hospice?	Yes ☐ No ☐

Diagnosis		New Diagnosis ☐	Progression of Disease ☐
Primary Diagnosis:		Date of Diagnosis:	
Metastases:			

Patient Aware of :	Diagnosis: YES NO	Prognosis: YES NO	Referral: YES NO
Family Aware of:	Diagnosis: YES NO	Prognosis: YES NO	Referral: YES NO

Comments:

DNACPR Status (tick one)	**YES (**documented) ☐	**NO** (not addressed yet) ☐	**NO** (not appropriate) ☐

Medical Details:	
Recent medical investigations /management	**Please enclose copies of recent correspondence & results and copy of Carenap if relevant**
Past Medical History	
Current Medication	

PLEASE COMPLETE ASSESSMENT BELOW BEFORE MAKING REFERRAL					
Description of symptoms	**Symptom Score**	**Give more details of symptom**	**Description of symptoms**	**Symptom Score**	**Give more details of symptom**
Pain			Urinary Problems		
Nausea			Mobility Problems		
Vomiting			Sleep Problems		
Anorexia			Fatigue		
Constipation			Sweats/Flushing		
Weight Loss			Patient Anxiety		
Dysphagia			Family Anxiety		
Mouth Problems			Other		
Dyspoea			Other		
Cough			**TOTAL SCORE**		

Symptom Score (Adapted from S.T.A.S. with permission of Irene Higginson)

0	Absent	3	Severe, present often and causing marked limitations to daily life
1	Occasional, not affecting daily life		
2	Moderate distress, causing some limitation to daily life	4	Overwhelming, continuous and dominating daily life

Comments / Main Issues for patient

Is patient fit to travel to Hospice YES ☐ NO ☐

Service being requested (please tick)		**Reason for Referral** (please tick)		**Urgency of Referral** (please tick)	
	Inpatient		Assessment / Management		ROUTINE (within 7 working days)
	Outpatient		Symptom Control		URGENT (within 2 working days)
	Domiciliary		Short structured respite		EMERGENCY
	Hospital Palliative Care Team		End of Life Care		
			Psychological Issues		
			Bereavement		
			Practical / Family issues		

Referral Made By:

Print Name:		Designation:	
Signature:		Date:	