Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

AFFIX LABEL HERE IF AVAILABLE

NHS Number: .....
District Number: .....
Surname: .....
Forename(s):.....
Address: .....
.....
D.o.B.:.....

DONCASTER COMMUNITY SPECIALIST PALLIATIVE CARE REFERRAL FORM

REFERRER DETAILS

Print Name: .....
Last Seen: .....
Sign: .....

Designation: .....
Telephone: .....
Date: .....

REASON FOR REFERRAL

☐ Pain ☐ Symptom Control ☐ Psychological ☐ Spiritual ☐ End of life ☐ Other (specify): .....
.....
.....

PATIENT DETAILS

Marital status: Single / Married / Widowed / Divorced / Partner

Religion: .....
Ethnic Origin: .....
Consultant Name: .....
Current location of patient: .....

Age: ..... Telephone No.: .....
Occupation: .....
Is an interpreter required? ☐ Yes ☐ No
Contact Number: .....

Smoker ☐ Yes ☐ No
Bariatric ☐ Yes ☐ No If 'Yes', please state weight: .....kg
Infection ☐ Yes ☐ No If 'Yes', please state: .....
Falls Risk ☐ Yes ☐ No If 'Yes', date of last fall: .....
Case Manager: .....
Which Community Team: .....

☐ **Patient aware of referral?**
☐ **Carer aware of referral?**
☐ **Medical team/GP aware of the referral?**
☐ **District Nursing Team aware of the referral?**

MAIN CARER / Next of Kin

Name: ..... Next of Kin? ☐Yes ☐No
Address: .....
Primary Contact: .....
Telephone: .....

Relationship: .....
Telephone: .....
Relationship: .....

GP Name: ..... Surgery: ..... Telephone: .....

DONCASTER COMMUNITY SPECIALIST PALLIATIVE CARE SERVICES

All referrals to be completed and faxed to:

Telephone: 01302 566666 **Fax: 01302 566665**

If you know the service you wish to refer to tick the relevant box below:

- ☐ Community Specialist Palliative Care Team
- ☐ Inpatient (Hospice)
- ☐ Consultant Opinion
- ☐ Day Hospice
- ☐ Counselling
- ☐ Bereavement support
- ☐ MDT discussion

If you are unsure of which service you require, tick here:

☐ St John's Hospice Specialist Palliative Care Services

(Please continue over...)

FURTHER INFORMATION

Patient Name: ..... D.o.B.: ..... NHS No.: .....

Referral letter attached? ☐ **Yes** ☐ **No** **GP notes/summary/discharge letter attached?** ☐ **Yes** ☐ **No**

Preferred Place of Care (Specify): .....

Fast Track package in place ☐ **Yes** ☐ **No** Do they have pre-emptives available? ☐ **Yes** ☐ **No**

Advanced Decision to Refuse Treatment in place? ☐ **Yes** ☐ **No** Any Advance Directive? ☐ **Yes** ☐ **No**

DNACPR Status (Specify): .....

PLEASE COMPLETE BELOW: ADD ADDITIONAL INFORMATION (Letter/summary if available).

Diagnosis: .....

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Summary: *(Must include past medical history, details of referral, current medications, what has been tried, any allergies, attach separate sheet if necessary)*

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What would you like from Specialist Palliative Care?

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Is patient already known to a Specialist palliative care team or a Specialist nurse / service e.g. Lung CNS? ☐ **Yes** ☐ **No**

If yes, who: .....

When were they last seen? .....

Any future appointments: .....