SUPPORTIVE CARE REFERRAL

Please complete **all shaded sections** and return to:
MACMILLAN WELLBEING CENTRE, MOORSIDE ROAD, DAVYHULME, M41 5SN
TELEPHONE: 0161 746 2080

Referral criteria:	18 years or over T Trafford resident or registered with Trafford GP	Allergy sticker:

Date			Please indicate √ :			
CLIENT DETAILS			Patient with diagnosis		or	Family/ carer	
Title			FOR OFFICE USE ONLY: Client ID code: Family/ carers known to service?		SCA date:	
Name						
Address			D. o. B.			
			Gender			
			Ethnicity			
Postcode			NHS number			
Contacts Voicemail? Y / N	Home no.		GP name GP address GP no.			
	Mobile no.					
	E-mail					
Emergency contact	Name		Consultant			
	Address		Hospital			
	Phone		District/ Macmillan nurse			

REFERRER'S DETAILS			
Nature of referral- please indicate √ :			
Self		GP/ health professional	
Family/ carer (with permission)		Other	
Name		Name and role	
Relationship to client:		Telephone	
		Address	
In centre referral taken by….			

Continued over……

Diagnosis	
Reason for referral	
Current situation	

ADJUSTMENTS REQUIRED			
Accessibility (e.g.wheelchair) details			
Interpreter needed?	yes / no	Home language	
Any other relevant information			

FOR OFFICE USE ONLY					
Client understands and accepts referral	yes / no	Consent given for assessment	yes / no	Consent for EMIS shared record access	yes / no
Confidentiality explained	yes / no	Compliments/ complaints procedure explained	yes / no	Possible transport needs	yes / no

Received by:	*Telephone*	*Face to face*	*Post*	*E-mail*	*Date:*