**Trafford Palliative Care Service Referral Form**

**IF YOUR REFERRAL IS URGENT PLEASE CONTACT THE OFFICE**

**\*Please ensure that your patient has a District Nurse referral too as we are not a 24hour service\***

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| **PATIENT DETAILS (Attach Label)**  Surname ……………………………….………..  First Name ……………………………………..….  Known as ….…………...................…  Address ………………………………  ……… …………………………….......  Post Code …………………………….  Telephone …………………………….  NHS number. ....................................  Date of Birth ………………………… | | **Civil Status;**  Married/Separated  Civil Partnership  Single  Widowed  Divorced  Cohabiting  Occupation (or last occupation)  …………………………........  Lives alone Yes/No | | | **Ethnic Status** – please tick  White British Black Caribbean  White Irish Black African  Other white Other Black  Indian Chinese  Pakistani Other  Bangladeshi Not stated  Other Asian  Mixed white/black Caribbean  Mixed white/black African  Mixed white/Asian  Other mixed  Language.................................................  Is interpreter required; Yes/No  Religion ……………..……………………. | | | | |
| **Is the patient aware of the referral?** Yes / No  **Is the patient’s next of kin aware of the referral?** Yes / No  **Has the patient given consent for their information to be shared?** Yes / No | | | | | | | | | |
| **NEXT OF KIN DETAILS**  Surname …………………………………………  Name ………………...……………………….  Relationship ………………………………………....  Address…….……………………..….  …..………………………………..…...  …………………………………..…….  Post Code ….…………...……………  Telephone …………………………… | | **GENERAL PRACTITIONER**  Name ……………………………...…  Practice………………………………  Address………………………………  ………………………………………..  Post Code ………………………..…  Telephone ………………………..…  Fax……………………………………  NHS.Net Email  ………………………………………..  GP aware of referral: Yes/No | | | **REFERRER DETAILS**  Name ………………………………………  Designation ...…………...........................  Department ………………………………  Address ……………………………………  …………….........……….…………………  Post Code ….…………………………….  Telephone............………..…..…...………  Fax…………..…...………….…………….  NHS.Net Email  ……………………………………..…….. | | | | |
| **PLEASE NOTE ALL THE DETAILS ABOVE ARE MANDATORY FIELDS** | | | | | | | | | |
| **Diagnosis (e.g. Primary and secondary cancer, non-malignant disease)**  Date(s) of diagnosis:  **Is patient aware of their diagnosis?** Yes / No  **Is the patient aware of their prognosis?** Yes / No | | | | | | | | | |
| ***PLEASE SEND COPIES OF RELEVENT CLINICAL CORRESPONDENCE WITH THIS FORM*** | | | | | | | | | |
| **Current Services Involved** | **Name** | | | **Base** | | | **Telephone No.** | | |
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| **Current Problems (For Manchester & Trafford residents)** | | | | | | | | | |
| 1.Activities of daily living |  | | 8. Family support & advice |  | | 15. Pain & Symptom Management | | |  |
| 2. Assessment |  | | 9. Fatigue |  | | 16. Palliative Care | | |  |
| 3. Bereavement support |  | | 10. Goal setting |  | | 17. Psychological Support | | |  |
| 4. Body Image |  | | 11. Indirect contact/advice |  | | 18. Respiratory | | |  |
| 5. Breathlessness |  | | 12. Lymphoedema |  | | 19. Stress/anxiety management | | |  |
| 6. End of Life Care |  | | 13. Mobility |  | | 20. Supportive D/C | | |  |
| 7. Exercise rehabilitation |  | | 14. Moving and Handling |  | | 21. Vocational | | |  |
|  |  | |  |  | | 22. Nutrition | |  | |
| **Current Problems (For Manchester residents only)** | | | | | | | | | |
| 1. Speech & Voice |  | | 1. Dysphagia |  | |  | | |  |
| **CURRENT MEDICATION + ALLERGIES** | | | | **PAST MEDICAL HISTORY**  Has the patient been fitted with:  a) A cardiac pacemaker/ implanted defibrillator? YES/NO  b) Radioactive or other implant? YES/NO | | | | | |
| **SOCIAL SITUATION**  e.g. housing, family, financial | | | | | | | | | |
| **Please tick box if following has been discussed/is in place**  Palliative Care Register Six Steps register Anticipatory Drugs  Do Not Attempt Resuscitation Statement of Intent Preferred Priorities Care  Living Will/Advance Directive Power of Attorney Power of Attorney (Health & Welfare) (Property & Financial)  CHC applied for Yes /No Date submitted: | | | | | | | | | |
| Please clearly state what the priorities are for the first visit including information of any screening tool (MUST, Pain Assessment etc) and treatments carried out. | | | | | | | | | |
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| **Referrers Signature: Date of Referral:** | | | | | | | | | |