

North Devon Hospice, Barnstaple, North Devon EX32 0HU

[www.northdevonhospice.org.uk](http://www.northdevonhospice.org.uk) registered charity no. 286554

being there for all the family

**REFERRAL FORM**

## **Referral Criteria**

* Has a life limiting diagnosis (patients only)
* Has complex problems that cannot be adequately addressed by current caring team
* If referring a patient with a life limiting condition, please complete Section 1 only
* If referring a family member/carer, please complete section 2 only (DO NOT complete patient details if the patient is not being referred)
* If referring a patient and a family member – Please compete sections 1 & 2

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| Is the GP aware of the referral | Yes [ ]  No [ ]  |
| Is the person aware of the referral? | Yes [ ]  No [ ]  |
| Has the person given consent for our services | Yes [ ]  No [ ]  |
| If necessary is it OK for North Devon Hospice to see supporting information from GP  | Yes [ ]  No [ ]  |

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| **Referrer’s details**  |
| Name:       | Role:       | Date       |
| Organisation & contact details:      |
| **If You Feel This Referral Requires Urgent Action, Please Contact Us To Discuss Next Steps 01271 344248** |

**SECTION 1**

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| **Details of the patient being referred** |
| Title:       | Forename:       | Surname:       |
| Address:       |
| Postcode:       | Landline:       | Mobile:       |
| Email:       |
| Age:       | Date of Birth (dd/mm/yyyy):       | NHS Number:       |
| Religion:        | Ethnicity:        | Gender: Male [ ]  Female [ ]  Unspecified [ ]  |
| Location of the person you are referring (if they are not at the address given):       |

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| **Next of kin / Main carer details** |
| Name:        | Relationship:       |
| Address:        | Telephone Number |
| Are they? Next of kin [ ]  Main carer [ ]   |

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| **GP –** please complete all sections |
| GP’s name:       | GP Practice:       |
| Other agencies involved in supporting this person:      * Community services
* Mental health services
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| **Please tell us why you are referring this person to North Devon Hospice -** please complete all sections |
| * Primary diagnosis:
* Any Metastases
* Any other significant diagnosis.
* Any mental health issues (historical or current)
 |       |
|  Date of diagnosis:       | Prognosis:       |
| What prompted you to contact us today?* What palliative care needs does the patient have?
* What are the current issues for the patient?
* Please indicate a current performance status e.g. Karnofsky, ECOG, Rockwood frailty score, WHO – please specify
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| **Other Relevant Information:** |
| Advance Care Plan completed [ ]  | Any communication issues?       | Are there any risks we should be aware of?        |
| Treatment Escalation Plan (TEP) [ ]  |
| Person lives alone: Yes [ ]   |
| Preferred first contact? (If this is not the patient, we will need the patient’s permission to speak to the person)       |

**SECTION 2**

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| **Details of Family Member/Carer needing support:** |
| Title:       | Forename:       | Surname:       |
| Address:       |
| Postcode:       | Landline:       | Mobile:       |
| Email:       |
| Age:       | Date of Birth (dd/mm/yyyy):       | NHS Number:       |
| Religion:        | Ethnicity:        | Gender: Male [ ]  Female [ ]  Unspecified [ ]  |

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| **Complete this section if the person you are referring is under 16** |
| Guardian’s name:       |
| Guardian’s contact details:       |

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| **GP –** please complete all sections |
| GP’s name:       | GP Practice:       |
| Other agencies involved in supporting this person:      * Community services
* Mental health services
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| **Please tell us why you are referring this person to North Devon Hospice -** please complete all sections |
| What prompted you to contact us today?* What needs does the person being referred have?
* What are the current issues?
 |       |