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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 |

|  |  |  |
| --- | --- | --- |
| **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**

|  |  |  |  |
| --- | --- | --- | --- |
| **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**

|  |  |  |  |
| --- | --- | --- | --- |
| **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: |

|  |  |
| --- | --- |
| **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? |  |