Thames hospice

EAST BERKSHIRE PALLIATIVE CARE REFERRAL FORM

via Single Point of Access (SPA)

Please complete both pages - incomplete forms will be returned to referrer

Inpatient, Community and Wellbeing Services

To make a referral, please complete the form and email to thames.hospice@nhs.net or call 01753 848925

Referrer:	Contact no:	Date:
Profession:	Organisation:	

Surname:	NHS no:
First name:	Marital status:
DOB:	Age:
Male/female:	Religion:
Ethnicity: (please specify)	Language spoken:

HAS THE PATIENT CONSENTED TO REFERRAL?	**YES**	**NO**
If patient lacks capacity, has a Best Interests decision been made?	**YES**	**NO**

Address:	NOK: Relationship to patient: Tel no:
Postcode:	1st contact: Patient/ NOK/ other
Telephone no:	Mobile:

PRIMARY DIAGNOSIS and DATE:
Recent treatment:

GP surgery: Tel no:	Acute treatment centres /hospitals:
GP:	Consultant (1):
DN:	Consultant (2):
Other HCP:	Site Specific Nurse:

WHICH SERVICE DO YOU WANT TO REFER THE PATIENT TO:			
Thames Hospice Inpatient Unit (IPU)		**Ambulatory Care**	
Symptom control		Blood transfusion	
End-of-life care		Iron transfusion	
Assessment of care needs		Bisphosphonate therapy	
Respite			
Community Support and Wellbeing			
Palliative care assessment with CNS		Lymphoedema service	
Medical review with Specialty Doctor		Complementary therapy	
Symptom control		Occupational therapy	
Emotional support		Medical outpatient appointment	
Children & family specialist support		Bathing service	
Advice/Advanced Care Planning/ReSPECT		Prognosis, education and support session	
Social/financial advice		Family and carer support and education session	
Neurological support service		Family and carer bereavement support session	
Physiotherapy and Rehabilitation Centre		Young persons' support session	
Day programme of wellbeing activities		Art and gardening therapy	

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Patient Name:	NHS no:

Information relevant to referral including details of symptoms/problems:

ESTIMATED PROGNOSIS: Days Weeks Months

Patient aware ☐

Contact is made with all referrals within 24 hrs for assessment/triage and prioritised according to needs

PAST MEDICAL HISTORY:	
Diagnosis:	**Date:**

CURRENT MEDICATION:		
(Only needs completion if medication list not attached)	**Dose**	**Frequency**

ALLERGIES:	**Date:**

Please attach the following information to enable the registration and assessment process:

GP medical summary print out including medication list ☐

Copies of relevant Consultant letters, discharge summaries and investigation results ☐

Preferred place of care/death:

Home ☐ **Hospice** ☐ **Hospital** ☐ **Nursing Home** ☐ **Other** ☐

Please tick below as appropriate:	**Yes**	**No**	**Unknown**
For Acute Trust transfer in event of deterioration			
DNACPR completed			
Pre-emptive medication prescribed			
Advance Care Plan in place			
Continuing health care funding in place			
Package of care in place			
Equipment in place			
Lives alone			