

Specialist Palliative Care Referral Form

Kent & Medway Network

July 2015

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Patient Details		
Surname	Male/Female	Office use
First Name		
Address	DoB	
Post Code	Ethnicity	
Telephone:		
Mobile Telephone	NHS No:	
Place of care at present: HOME/HOSPITAL/NURSING HOME/RESIDENTIAL HOME		
Patient lives alone: YES/NO Patient has consented to referral Yes <input type="checkbox"/> No <input type="checkbox"/>		

Primary diagnosis(es) and key treatments	Treatment is:
	Curative <input type="checkbox"/> Palliative <input type="checkbox"/>
	Gold Standards Framework Register <input type="checkbox"/>
ALLERGIES:	

Service Requested
Home Care <input type="checkbox"/> Hospital Care <input type="checkbox"/> Day Care <input type="checkbox"/> Hospice Admission <input type="checkbox"/>
Psychological/Social Support <input type="checkbox"/> Lymphoedema <input type="checkbox"/> Carer Support <input type="checkbox"/> Other _____
Special Consideration
First language if not English _____ Communication in English Good/Fair/Poor
Other barriers to communication – e.g. hearing loss/confusion
Would an interpreter be helpful YES/NO
Other consideration Disability/Bariatric Care
Infection status

Next of Kin/Main Carer	Services Involved:	General Practitioner
Name	District Nurse YES <input type="checkbox"/> NO <input type="checkbox"/>	Name
Telephone	Social Services	Address
Mobile telephone	Care Manager YES <input type="checkbox"/> NO <input type="checkbox"/>	Postcode
	Specialist Nurse YES <input type="checkbox"/> NO <input type="checkbox"/>	Telephone
	Team _____	Fax/email:
	(Please specify)	PCT number:
	Community Matron YES <input type="checkbox"/> NO <input type="checkbox"/>	

DNACPR Completed <input type="checkbox"/> Not Completed <input type="checkbox"/>

IS REFERRAL URGENT (assess with 2 working days)? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

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Name _____

Date of Birth _____

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Inpatient details

Hospital _____

Consultant _____

Ward _____

Telephone _____

Date of discharge (if known/planned) _____

Extension _____

Is Hospital Palliative Care Team involved YES NO

Current issues/problems (e.g. symptoms, psychosocial issues, insight)

-
-
-
-
-

Medication

SC infusion in progress YES NO

Please attach medication list/TTO's

Transdermal patch YES NO

Clinical correspondence attached:

Recent hospital letters YES

Medication list/TTO's YES

GP enhanced encounter form

Other

Other comments (e.g. insight, psychosocial issues)

Person completing this form:

Name _____ Designation _____ Contact details _____

Location _____ Date _____

Ashford

Pilgrims Hospice

Telephone: 01233 504100
Email: PH.PilgrimsHospices@nhs.net

Canterbury

Pilgrims Hospice

Telephone: 01227 812612
Email: PH.PilgrimsHospices@nhs.net

Dartford & Gravesham

Ellenor Lions Hospices

Telephone: 01474 538508
Fax: 01474 326260

Maidstone

Heart of Kent Hospice

Telephone: 01622 792200
Fax: 01622 718920

Medway & Swale

Wisdom Hospice

Telephone: 01634 830456
Email: wisdom.hospice@nhs.net

QEQM Hospital

Telephone: 01843 225544
Fax: 01843 220048

Thanet

Pilgrims Hospice

Telephone: 01843 233920
Email: PH.PilgrimsHospices@nhs.net

Tunbridge Wells

Hospice in the Weald

Telephone: 01892 820500
Fax: 01892 820520
clinical@hitw.org.uk

William Harvey Hospital

Tel/Fax: 01233 616024

Kent & Canterbury Hospital

Tel: 01227 766877 x 736 Bleep 238

Darent Valley Hospital

Telephone: 01322 428293
Fax: 01322 428294

Maidstone Hospital

Telephone: 01622 225024
Fax: 01622 225116

Medway Maritime Hospital

Telephone: 01634 833807
wisdom.hospice@nhs.net

Kent and Sussex Hospital

Telephone: 01892 632346
Fax: 01892 632939