The Prince & Princess of Wales Hospice

**Prince & Princess of Wales Hospice**
**20 Dumbreck Road, Glasgow G41 5BW**
Tel: 0141 429 9823 Website: www.ppwh.org.uk
Secure email (from nhs accounts): ggc.ppwhclinicaladmin@nhs.scot

| REFERRAL FOR | | | | | | |
|---|---|---|---|---|---|---|
| Community Palliative Care: | Hospice Community Team | ☐ | | | | |
| Outpatient Services: | Day Services | ☐ | Outpatient Medical Clinic | ☐ | Nurse-led Clinic | ☐ |
| Inpatient Admission: | Symptom Control | ☐ | End of Life Care | ☐ | Assessment | ☐ |
| *For more information about what each service offers, please refer to our website* | | | | | | |

| REFERRED BY | | | |
|---|---|---|---|
| Name: | | Contact number: | |
| Designation: | | Date: | |

| PATIENT DETAILS | | | |
|---|---|---|---|
| Surname: | | DoB: | |
| Forename: | | CHI: | |
| Address: | | Postcode: | |
| | | Tel. No.: | |
| Religion: | | Marital status: | Please select from menu |
| Ethnicity: | Please select from menu | Is patient aware that referral is being made? | ○ Yes ◉ No |
| Current location of patient: | | | |

| IF REFERRING FROM HOSPITAL | | | |
|---|---|---|---|
| Hospital: | | Ward: | |
| Consultant: | | Tel. No.: | |

| NEXT OF KIN DETAILS | | | |
|---|---|---|---|
| Surname: | | Address: | |
| Forename: | | | |
| Relationship to patient: | | Postcode: | |
| Tel. No.: | | Aware of referral: | |

IMPORTANT - Completed referral forms should be submitted via secure nhs email
ggc.ppwhclinicaladmin@nhs.scot

| GP DETAILS | | | |
|---|---|---|---|
| Name: | | Address: | |
| Tel No.: | | | |
| Postcode: | | | |
| Aware of referral: | | | |

| SOCIAL SUPPORT | | | | | |
|---|---|---|---|---|---|
| Lives with: | | | | DN in attendance? | ◯ Yes ◉ No |
| DN Name: | | | | DN Tel No: | |
| Care Package? | | Details: | | | |

| MEDICAL INFORMATION | | | | | |
|---|---|---|---|---|---|
| Diagnosis: | | | | Date of Diagnosis: | |
| Metastatic Disease: | | | | | |
| Treatment to date (surgery, chemotherapy, radiotherapy etc.): | | | | | |
| Patient's understanding of disease & prognosis: | | | | | |
| Mobility: | | | | Housebound? | ◯ Yes ◉ No |
| Personal care: | | Continence: | | | |
| Past medical history: | | | | | |
| Current medication: | | | | | |
| Allergies: | | | | Pacemaker? | ◯ Yes ◉ No |

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## CURRENT ISSUES

*Please choose the severity of the following from 0 to 4; 1 being none and 4 being overwhelming*

| | | | |
|---|---|---|---|
| Agitation | ◉0 ○1 ○2 ○3 ○4 | Spiritual/existential distress | ◉0 ○1 ○2 ○3 ○4 |
| Nausea/vomiting | ◉0 ○1 ○2 ○3 ○4 | Patient distress/anxiety | ◉0 ○1 ○2 ○3 ○4 |
| Dyspnoea | ◉0 ○1 ○2 ○3 ○4 | Family distress/anxiety | ◉0 ○1 ○2 ○3 ○4 |
| Constipation | ◉0 ○1 ○2 ○3 ○4 | Confusion | ◉0 ○1 ○2 ○3 ○4 |
| Ascites | ◉0 ○1 ○2 ○3 ○4 | Depression | ◉0 ○1 ○2 ○3 ○4 |
| Distress due to care environment | ◉0 ○1 ○2 ○3 ○4 | End of life care (last 48 to 72 hours of life) | ◉0 ○1 ○2 ○3 ○4 |
| Other (please specify) | | | |

| | | | |
|---|---|---|---|
| Pain (please give numerical scale rating) | No pain | ◉1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 | Severe Pain |

## REASON FOR REFERRAL

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