Hospice Referral Form

**The Prince & Princess of Wales Hospice**
**20 Dumbreck Road, Glasgow G41 5BW** Tel: 0141 429 9823 Website: www.ppwh.org.uk
Secure email (from nhs.net 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* |

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: |  |
| Ethnicity: |  | 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: |  |

## 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 |

## CURRENT ISSUES

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Agitation | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Nausea/vomiting | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Dyspnoea | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Constipation | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Ascites | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Distress due to care environment | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Spiritual/existential distress | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Patient distress/anxiety | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Family distress/anxiety | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Confusion | [ ]  0 | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| Depression | [ ]  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):  | [ ]  0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10  |

##  REASON FOR REFERRAL

|  |
| --- |
|  |