Hospice Referral Form

A logo with text on it

AI-generated content may be incorrect.**The Prince & Princess of Wales Hospice**  
**20 Dumbreck Road, Glasgow G41 5BW** Tel: 0141 429 9823 Website: www.ppwh.org.uk  
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# 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* | | | | | | |

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## 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

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| --- |
|  |