# **Referral Form**

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| **Date of referral:**  **Time of referral:** |
| **Method of referral:** Telephone Verbal Written  Self |
| **Urgency:** Routine Urgent |
| **Referral for:** Inpatient Unit Medical Outpatient Medical Outreach Social Work Neuro Living Well☐ |
| **Referral taken by (Name):** |

*\* Please complete – essential information*

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| **Patient’s details** | | | |
| **\*Name:** | | **\*DOB/Age** | |
| Address:  Postcode: | | Phone number: | |
| Ethnicity/language: | **\*NHS No:** | | EMIS No: |
| Patients Current Location: | | | |

**\*Has the patient given consent to view & share medical records**  **YES/NO**

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| **Referrer’s details** | | | | | | |
| Name: | | | Position: | | | |
| Organisation:  Address: | | | Phone number: | | | |
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| **Clinical Details** | | | | | | |
| Diagnosis: | | | | | Date: | |
| **DNACPR:**  Yes  No  **Escalation plan**: Yes  No | | | | **Mental Capacity ?**  Yes  No  Best Interests Decision | | |
| **REASONS FOR REFERRAL -** *please tick all that apply* | | | | | | |
| Crisis at Home |  | Emotional /Psychological Support | | | |  |
| Respite |  | End of Life Support | | | |  |
| Symptom Control |  | Other – please give details :- | | | |  |
| No Care Package Available |  |
| **KEY ISSUES** | | | | | | |
| Other significant medical problems? Any mental health/psychological issues? | | | | | | |
| History of falls/falls risk? Yes No    Any possibility of C.diff, MRSA, or other infection: Yes  No | | | | | | |
| Does Patient Smoke – If YES please explain Hospice Smoking policy Yes  No  [EV.HS.06 Smoking Policy.pdf](https://edenvalleyhospice.sharepoint.com/:b:/s/EdenValleyHospiceJigsaw-InformationSite/EVamu8WeTyJJnr1Yhx0wITQBcMK-INhVO3f1IqgtFEjkEA?e=8vfKLw) | | | | | | |

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| **Home situation** | |
| Who does the patient live with? | |
| Who provides care? | How is care funded?  What is the Care Package? |
| Any other relevant issues relating to family, Next of Kin:  carers or home situation: Full name:    Contact details:  **Are there any Safeguarding risks?**  Finance  Health & Wellbeing  Yes  No  Unknown | |

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| **Key professionals** | |
| GP name & surgery: | Tel: |
| Consultant(s) name & location: | Tel: |
| CNS Palliative Care: | Tel: |
| Other relevant professionals: | Tel: |

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| **Other relevant information** |
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| **Action Taken** | | |
| Date: |  | Signature: |
| **Referral Rejected:** | | |
| Inappropriate Moved out of area Patient cannot be contacted Patient died Referred to hospital Patient refuses service Referred to another organisation Referred to another service within organisation | | |

**Please email to** [**evh.jigsaw@nhs.net**](mailto:evh.jigsaw@nhs.net)

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