# **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/%3Ab%3A/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**

**Version 7 – 13.12.2024**