Eden Valley Hospice

Referral Form

Date of referral:	**Time of referral:**
Method of referral: Telephone ☐ Verbal ☐ Written ☐ Self ☐	
Urgency: Routine ☐ Urgent ☐ 2week ☐	
Referral for: Inpatient Unit ☐ Day Hospice ☐ Outpatient ☐ Social Work ☐ Family Support ☐ Complementary Therapy ☐ Reiki Therapy ☐ Sunflower Carer's Group ☐	
Referral taken by (Name):	

Patient's Details		
Name:	DOB/Age	
Address: Postcode:	Phone number:	
Ethnicity/language:	NHS No:	EMIS No:

Referrer's Details	
Name:	Position:
Organisation: Address:	Phone number:

Clinical Details	
Diagnosis:	Date:
DNACPR: Yes ☐ No ☐	
Key issues/reason for referral:	
Other significant medical problems? Any mental health/psychological issues?	
Any possibility of C.diff, MRSA or other infection: Yes ☐ No ☐	
Does Patient Smoke – If YES please explain Hospice Smoking policy: Yes ☐ No ☐	

Home Situation	
Who does the patient live with?	
Who provides care?	
Any other relevant issues relating to family, carers or home situation:	First point of contact: Full name: Contact details: Do they have power of attorney?

Key Professionals	
GP Name: GP Surgery:	Tel:
CNS Palliative Care:	Tel:
Other relevant professionals:	Tel:

Other Relevant Information

Action Taken		
Date:		Signature: