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 Medical ☐ Outpatient Treatment ☐ Family Support ☐ Complementary Therapy ☐ Sunflower Carer's Group ☐ Social Work – Patient's ☐ Social Work – Families/carers ☐	
Referral taken by (Name):	

** Please complete – essential information*

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

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

Other relevant information

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 ☐		