

Specialist Palliative Care Referral Form

South London Palliative and Supportive Care Network

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|--|--|--|--|
| <input type="checkbox"/> Ellenor Foundation
(North Bexley)
Tel: 020 8310 4100
Fax: 020 8312 2115 | <input type="checkbox"/> Ellenor Foundation
(South Bexley)
Tel: 020 8308 3014
Fax: 020 8308 3168 | <input type="checkbox"/> Greenwich and Bexley Cottage Hospice
Tel: 020 8312 2244
Fax: 020 8312 4344 | <input type="checkbox"/> Greenwich Community Palliative Care Team
Tel: 020 8836 5432
Fax: 020 8836 5952 |
| <input type="checkbox"/> Guy's and St Thomas'
Guy's Site:
Tel: 020 7188 4754
Fax: 020 7188 4748 | <input type="checkbox"/> Guy's and St Thomas'
St Thomas' Site:
Tel: 020 7188 4755
Fax: 020 7188 4720 | <input type="checkbox"/> Princess Alice Hospice
Tel: 01372 468811
Fax: 01372 470937 | <input type="checkbox"/> Lewisham Macmillan Support Team
Tel: 020 8333 3017
Fax: 020 8333 3270 |
| <input type="checkbox"/> St Christopher's Hospice
Tel: 020 8768 4500
Fax: 020 8659 5051 | <input type="checkbox"/> St Raphael's Hospice
Tel: 020 8335 4575
Fax: 020 8335 4569 | <input type="checkbox"/> Harris HospisCare
Tel: 01689 825755
Fax: 01689 892999 | <input type="checkbox"/> Trinity Hospice
Tel: 020 7787 1000
Fax: 020 7787 1067 |
| | | <input type="checkbox"/> Marie Curie Hospice, Caterham
Tel: 01883 832600
Fax: 01883 832633 | |

(PLEASE TICK)

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Essential Patient Details

Surname		Male/Female	Age:	Patient consent to palliative care involvement Yes <input type="checkbox"/> No <input type="checkbox"/>	
First Name		DoB		Is GP aware of referral Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address		Marital Status		Office Use:	
Post Code		Ethnicity			
Tel		Mobile Tel			
NHS number		Hospital No.			

Primary diagnosis(es)

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Communication

Fluent in English? Yes <input type="checkbox"/> No <input type="checkbox"/> (If 'no' proceed with remaining questions)	Other barriers to communication:
First Language if not English:	
Would interpreter be helpful to patient and Palliative Care staff? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Next of Kin/Patient Representatives

Name	Name	Name
Address	Based at	Address
Telephone	Telephone	
	Fax	
Relationship to patient		Postcode

Main Carer (if different from above)

Name	Name	Telephone
Telephone	Based at	Fax/email
Relationship to patient	Tel	PCT number:
	Fax	
	Continuing care assessment completed: Yes/No	

Reason for Referral

Pain/symptom control <input type="checkbox"/>	Home assessment and support <input type="checkbox"/>	At Home <input type="checkbox"/>
Emotional/psychological support <input type="checkbox"/>	Hospital assessment <input type="checkbox"/>	In Hospital (see over) <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Day Care <input type="checkbox"/>	Other e.g. Nursing Home <input type="checkbox"/>
Assessment for hospice admission <input type="checkbox"/>	Admission (circle) <input type="checkbox"/>	
Carer support <input type="checkbox"/>	respite / symptom control / terminal care	Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other reason e.g. (spiritual, lymphoedema) <input type="checkbox"/>		
	MRSA Status Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known <input type="checkbox"/>	

Referrer's Name: (please print)	Contact number:	Bleep no:
Hospital/Surgery:	This information required on both pages if faxing	

IS REFERRAL URGENT (assess within 2 working days)? Yes No

IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE

