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| Referral To Leeds Specialist Palliative Care Services |





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| PATIENT DETAILS | |  | | |
| NHS No: | DOB: Click here to enter a date. | | | Gender: Please choose |
| Surname: | | | First Name(s): | |
| Address: | | | Post Code: | |
| Tel. Home: | Mobile: | | | Civil State: Choose an item. |
| Religion: | Ethnic Origin: | | | First Language: |
| Patient consented to referral: Yes  No | | | | |
| Referral for: Community Palliative Care Team  Out-Patient  Hospice Admission  Day Hospice | | | | |

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| REASON FOR REFERRAL |  |
| Main Palliative Diagnosis: | |
| Reason(s) for referral:  Pain  Nausea  Vomiting  Breathlessness Confusion/Delirium  Emotional support  Advance Care Planning  End of life | |
| Further information | |

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| ADVANCE CARE PLANNING |  |
| Has patient? A statement of wishes including preferred place of care Yes  No  Advance decision to refuse treatment Yes  No  Nominated a lasting power of attorney Yes  No | |
| If so, please give further details: | |

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| NEXT OF KIN DETAILS | |  | | |
| Surname: | | | First Name: | |
| Address: | | | Post Code: | |
| Tel. Home: | Tel. Other: | | | Mobile: |
| Relationship: | | | Aware of referral: Yes  No | |

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| REFERRING PERSON |  | | |
| Name: | | Designation: | |
| Location: | | Post Code: | |
| Tel: | | Date: Click here to enter a date. | |
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| GP PRACTICE |  | | |
| Practice: | | | |
| GP Name: | | | |
| Address: | | | |
| Contact Number: | | | |
|  | | | |
| EMAIL the form to the appropriate palliative care team: | | |  |
| St Gemma’s Hospice: [stg.community@nhs.net](mailto:stg.community@nhs.net)  Registered Charity No. 1015941  Wheatfields Hospice: [communitynursespecialist.wheatfieldshospice@nhs.net](mailto:communitynursespecialist.wheatfieldshospice@nhs.net) Registered Charity No. 1052076 | | | |