Referral To Leeds Specialist Palliative Care Services

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 ☐

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

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:

NEXT OF KIN DETAILS

Surname: First Name:

Address: Post Code:

Tel. Home: Tel. Other: Mobile:

Relationship: Aware of referral: Yes ☐ No ☐

REFERRING PERSON

Name:	Designation:
Location:	Post Code:
Tel:	Date: Click here to enter a date.

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
Registered Charity No. 1015941

Wheatfields Hospice: communitynursespecialist.wheatfieldshospice@nhs.net
Registered Charity No. 1052076