**Barnsley Specialist Palliative Care Referral Form**

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| Surname: First name(s): | |
| Date of birth: Age: | NHS No: |
| Address: | Hospital No: |
| Marital/civil status: |
| Ethnic origin: |
| Postcode: | Religion: |
| Telephone: | Current location of patient: |
| Is an interpreter required? Yes No  If yes, which language? | Infection Risk:  Is the patient a smoker Yes No  If yes, are they aware of the hospice policy? |
| DNACPR in place? Yes No | Is patient on O2? Yes No If yes: L/min |
| Has patient consented to discussion with the service? Yes No | Is consultant/GP aware of referral? Yes No |
| Is this a patients relative? Yes No |

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| **1st CONTACT** Name: | **2nd CONTACT** Name: |
| Relationship: | Relationship: |
| Address:  Tel no: | Address:  Tel no: |

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| **GP Name**: | **Name and contact details of other professionals involved**:  (Clinical Nurse Specialists, Community nurses etc.) |
| Address: |  |
| Telephone: |  |

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| **TYPE OF REFERRAL (please tick)** Urgent Routine |
| **Barnsley Community Specialist Palliative Care team:**  **Email:** [**swy-tr.rightcarebarnsleyintegratedspa@nhs.net**](mailto:swy-tr.rightcarebarnsleyintegratedspa@nhs.net) **Tel no: 01226 644575**  Community Macmillan Nurse  Community Macmillan Allied Health Professional /Social Worker (please specify): |
| **Barnsley District Hospital: email:** [**bdg-tr.palliativecare@nhs.net**](mailto:bdg-tr.palliativecare@nhs.net) **Tel no: 01226 434921**  Barnsley Hospital Specialist Palliative Care Team |
| **Barnsley Hospice: Email:** [**bdg-tr.barnsleyhospice@nhs.net**](mailto:bdg-tr.barnsleyhospice@nhs.net) **Tel no: 01226 244244**  Inpatient Unit **Prior to sending, please ring the hospice to discuss (including transport requirements)**    Medical Outpatient Clinic/Medical Home Visit    The Orangery/Support and Wellbeing Service    Counselling |

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| **PATIENT Name: Date of birth: NHS No:** |

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| **DIAGNOSIS & PAST MEDICAL HISTORY** Include dates:  Is the patient aware of their main diagnosis? Yes No |

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| **REASON FOR REFERRAL (Please tick all that apply):**  Pain Symptom control Last days of life care Psychological Spiritual  Social/Family Assessment for Palliative Care admission  Other Please specify: ………………………………. |

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| **SUMMARY OF MAIN CONCERNS INCLUDING CURRENT INTERVENTIONS:** |
| ***Please highlight any safety concerns here*** |
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| **MEDICATION HISTORY INCLUDING ALLERGIES:** |
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| **SOCIAL HISTORY:** |
| Is patient funded under Continuing Care? Yes No |

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| **REFERRED BY:** | Post: | Contact no: |
| Date of referral: | Base: | Total no pages: |

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**Reviewed October 2021**