**Barnsley Hospice Referral Form**

Please note we cannot accept a referral if any of the following information is incomplete.

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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? | Gender  Male  Female  Other  Non-binary  Prefer not to say |
| ReSPECT in place? Yes No |
| Does the patient have a disability? Yes No | Sexual orientation: |
| Is the patient a carer? Yes No | Is the patient pregnant or breastfeeding?  Yes  No |
| Is the patient a smoker Yes No  If yes, are they aware of the hospice policy? | Is patient on O2? Yes No  If yes: L/min |
| Is consultant/GP aware of referral? 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** Urgent Routine |
| **Barnsley Hospice: Email:** [**bdg-tr.barnsleyhospice@nhs.net**](mailto:bdg-tr.barnsleyhospice@nhs.net) **Tel no: 01226 244244**  Inpatient Unit **If referring outside of office hours please phone IPU to inform of referral**  Medical Outpatient Clinic or Medical Home Visit  The Orangery/Support and Wellbeing Service  Counselling |
| **CONSENT/CAPACITY:**  Has the person named above consented to the referral?  If the patient lacks the capacity to consent to the referral has a best interest decision been made?  Yes  No (please state why) ………………………………………………………….……………..  In consultation with a Health Care Professional (referrer). Does the patient consent to the collecting, sharing, processing and viewing of data recorded with any other organisation that may care for the patient.  Consent given Consent refused  The patients consent can be changed at any time.  PATIENT Name: Date of birth: NHS No: |
| **DIAGNOSIS & PAST MEDICAL HISTORY** include dates:  Is the patient aware of their main diagnosis? Yes No  Does patient have a pacemaker? Yes No Does patient have an ICD? Yes No  **Infection risks** (e.g. MRSA, COVID 19, C. Diff, D+V, Other)**:** |

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| **SUMMARY OF MAIN CONCERNS:**  **REASON FOR REFERRAL** |
| **RISKS:**  *Please describe in detail any identified risks or safety concerns for example safeguarding issues, drug or alcohol use, risks to the lone worker, falls risks, current pressure areas, cognitive impairment, mental health risks.* |

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| **CURRENT MEDICATION INCLUDING ALLERGIES:** |
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| PATIENT Name: Date of birth: NHS No: |
| **SOCIAL HISTORY:** |
| Is patient funded under Continuing HealthCare? Yes No |
| **ADDITIONAL RELEVANT INFORMATION:** |

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

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