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**WIGAN & LEIGH HOSPICE PALLIATIVE AND END OF LIFE CARE SERVICES**

**REFERRAL FORM**

**Please use this form for all referrals to Wigan & Leigh Hospice.** **Please ensure you complete both sides of the form fully. If we have to contact you for further details, there will be a delay in processing the referral. Send the completed form to:** WIGAN & LEIGH HOSPICE, Kildare Street, Hindley, Wigan WN2 3HZ

Telephone: 01942 525566 Email: wlhospice.admin@nhs.net

If there are complex issues please send a covering letter and/or copies of hospital letters, or contact the service by telephone to discuss the problems.

|  |  |
| --- | --- |
| **Referrer:** | **Tel No:** |

**SERVICE REQUIRED** – Please tick as appropriate

|  |  |
| --- | --- |
| Community Hospice Nurse Specialist (Outpatient clinic/ Domiciliary visits) |  |
| Hospice in your Home  *(Patient must be known to District Nursing service. If urgent response needed please*  *send referral & leave message for Hospice in Your Home Co-ordinator on 07551 153266.)* | Medical Outpatient Clinic |
| Hospice in Your Care Home  *(Referrals from Care Home staff only)* | Inpatient Unit Admission |

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| --- |
| Have you already discussed this patient with hospice staff? Yes/No  If Yes, who have you spoken to? |

**PATIENT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: | Forename: | | DOB: |
| Home/Care Home Address: | | | |
| Postcode: | Tel No: | | Marital status: |
| NHS Number: | Ethnic group: | | Does patient live alone? Yes/ No |
| Next of kin: | Relationship to Patient: | | |
| NoK Address: | | | NoK Tel No: |
| Patient’s current location *(Please tick):*  Home □ *Access/ safety issues:*  Care Home□ | | Hospital □ *Name of hospital & ward:*    Other location □ *Give details:* | |
| GP: | | | Is GP aware of referral ? Yes / No |
| GP’s Address: | | | Tel No: |
| Consultant(s): | | | Hospital(s): |

**CONTINUED OVERLEAF**

|  |  |
| --- | --- |
| **Patient Name:** | **NHS Number:** |

**CLINICAL DETAILS**

|  |  |  |
| --- | --- | --- |
| Diagnosis & extent of disease: | | |
| Estimated prognosis *(Please tick as appropriate)*:  Hours □ Days □ Weeks □ Months □ More than a year □ | | |
| Important events and treatments: | | |
| Other related conditions: | | |
| Any barriers to communication: | | |
| Any specific nursing needs: | | |
| Medication: | | |
| Does patient have an Advance Care Plan or any preferences for their future care? If Yes, give details: | | |
| Is patient on GSF Register?  *(Please circle):* Yes/ No/ N/A | Is Individual Plan of Care for the dying person in use? *(Please circle):* Yes/ No/ N/A | Is a DOLS in place?  *(Please circle):* Yes/ No/ N/A |

**REASON FOR REFERRAL** - Please tick relevant problem(s) & give details

|  |  |
| --- | --- |
| **Problem**  Pain/ symptom control □  Emotional/ psychological support □  Advance care planning □  Carer support □  Other reason □ | **Details** |

|  |  |
| --- | --- |
| **Patient Knowledge** *(Please circle):* | **Family Knowledge** *(Please circle):* |
| Patient consented to referral? Yes/ No/ Best Interests Decision  Patient aware of diagnosis/ prognosis? Yes/ No | Family aware of referral? Yes/ No  Family aware of diagnosis/ prognosis? Yes/ No |
| If No to any of the above, please state reason why: | |

**OTHER AGENCIES INVOLVED**

|  |  |
| --- | --- |
| **Social worker** | Name: Tel No: |
| **District nurse** | Name: Tel No: |
| **Disease-specific CNS** | Name: Tel No: |
| **Other professionals** | Name: Tel No: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** | **Name:** | **Designation:** | **Date:** |