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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

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| --- | --- |
| 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/NoIf 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**

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| 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

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| --- | --- |
| **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 DecisionPatient aware of diagnosis/ prognosis? Yes/ No | Family aware of referral? Yes/ NoFamily 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: |

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