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/fax completed form to: WIGAN & LEIGH HOSPICE, Kildare Street, Hindley, Wigan WN2 3HZ
Telephone: 01942 525566 Fax: 01942 525577

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) *(Patient must be known to District Nursing service unless resident in a nursing home)*	☐ Oak Centre
☐ Hospice in your Home *(Patient must be known to District Nursing service. If urgent response needed please fax 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)*	☐ Admission

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:* Hospital ☐ *Name of hospital & ward:* Care Home ☐ 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		**Details**
Pain/ symptom control	☐	
Emotional/ psychological support	☐	
Advance care planning	☐	
Carer support	☐	
Other reason	☐	

Patient Knowledge *(Please circle):*		**Family Knowledge** *(Please circle):*	
Patient consented to referral?	Yes/ No/ Best Interests Decision	Family aware of referral?	Yes/ No
Patient aware of diagnosis/ prognosis?	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:**