Wigan & Leigh Hospice

Wrightington, Wigan and Leigh NHS Trust

Ashton, Leigh and Wigan NHS Primary Care Trust

WIGAN SPECIALIST PALLIATIVE CARE SERVICES REFERRAL FORM

Please ensure you complete both sides of this form fully. If we have to contact you for further details, there will be a delay in processing the referral.

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

If there are any complex issues please consider sending a covering letter and/or copies of hospital letters, or contact our medical staff by telephone to discuss the problems.

From…… **Tel No**……

Request for
(Please tick as appropriate)

Admission ☐

Day Hospice ☐

Community Palliative Care Nurse Specialist ☐

Medical Outpatient Clinic
- Hospice ☐
- Thomas Linacre Centre ☐
- Either ☐

For Hospital Palliative Care Team (except Lung Cancer patients), please telephone referral to 01942 822009 or 244000 ext 2009

Hospital inpatients with Lung Cancer requiring Palliative Care should be referred to the Lung Cancer Specialist Nurse, telephone 01942 822260 or 244000 ext 2260

Have you already discussed this patient with a member of the Specialist Palliative Care Team? Yes/No

If so, who have you spoken to?.....

……

PATIENT DETAILS

Surname…… Forename…… DOB……..

Home Address…….....

Postcode…… Tel No:…….. Marital status……..

NHS Number…… Ethnic Group…… Does patient live alone? Yes/ No

Next of kin…….. Relationship to Patient ……

Address……..... Tel No:……..

Patient's current location *(Please tick)*:

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……

CONTINUED OVERLEAF

CLINICAL DETAILS

Diagnosis…….....

Extent of disease (e.g. sites of metastases)……...

Estimated prognosis *(Please tick as appropriate):* Days ☐ Weeks ☐ Months ☐ More than a year ☐

Important events and treatments……..

……

Other related conditions…….....

Medication……

……

REASON FOR REFERRAL

- **Patient has symptoms related to their life limiting illness which are complex or rapidly changing Yes / No**

If Yes, please give details of the symptoms you want us to help with and their current treatment:

……

……

……

- **Patient / Carer has difficulty adjusting to the diagnosis, advancing disease or change of circumstances Yes / No**

If Yes, please give details of the issues you want us to help with:

……

……

……

Patient Knowledge

Is patient aware of diagnosis? Yes/ No

Is patient aware of prognosis? Yes/ No

Is patient aware of referral? Yes/ No

Family Knowledge

Is family aware of diagnosis? Yes/ No

Is family aware of prognosis? Yes/ No

Is family aware of referral? 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 specialist nurse ☐ Name ……..Tel No:……

Other professionals ☐ Give details……..

Signed…….. **Name**…….. **Designation**…… **Date**……