

Patient Details		
Patient name:	Is the patient at home:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Known as:	Location if not at home:	
Address:	If patient in hospital please specify Ward:	
Post Code:	Does the patient live alone:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tel No:	Patient aware of and agrees to the referral:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of Birth:	Family aware of and agree to the referral:	Yes <input type="checkbox"/> No <input type="checkbox"/>
NHS No:	Carer / Next of Kin details	
Hospital No:	Name of main carer / Next of Kin:	
	Relationship to patient:	
	Contact details: <i>(if applicable)</i>	
Diagnosis of current problems		
Life limiting diagnosis is:		Date of Diagnosis:
Treatment to date and outcome of treatment (if appropriate):		
Future planned treatment and intent of treatment (ie curative, palliative):		
Current problems requiring Specialist Palliative Care input:	Reason for Referral:	
	End of Life care	<input type="checkbox"/>
	Pain Management	<input type="checkbox"/>
	Symptom Management	<input type="checkbox"/>
	Emotional and/or, Psychological Support	<input type="checkbox"/>
	Day Therapy Unit	<input type="checkbox"/>
Other significant information, including other medical conditions, psychological issues, social issues etc:		
Advance Care Planning		
Does the patient have a Advance Care Plan document:	PPC <input type="checkbox"/>	Advanced Decision <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
If Yes , where is the preferred place of care:	Home <input type="checkbox"/>	Nursing Home <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/>
Is the patient on Gold Standards Framework Register:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
GP and Surgery Details		
General Practitioner:	Is the GP aware of referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Surgery Address:	Is the DN team involved?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone Number:	(IF NO, PLEASE REFER)	
Other professionals involved (name and telephone number)		
Consultant(s):		
Clinical Nurse Specialist:	District Nurse:	
Social Services:	Nominated Key Worker:	
Referrer's Details (Form must be signed by GP, Senior Hospital Doctor or CNS)		
Name of Referrer: <i>(PRINT)</i>	Designation:	Date of Referral
Signature or Email address of Referrer:	Contact number:	

PLEASE INCLUDE COPIES OF CURRENT MEDICATION LIST AND RELEVANT CLINIC LETTERS, ONCOLOGY ANNOTATIONS, ETC.

Completed referrals should be posted, faxed or emailed to: Trinity Hospice, Low Moor Road, Bispham, Blackpool, FY2 0BG
 Telephone: 01253 359379 Fax: 01253 595654 Email: Referrals@trinityhospice.co.uk

Incomplete forms will not be accepted and will delay the referral process