WAKEFIELD HOSPICE
REFERRAL FOR SPECIALIST PALLIATIVE CARE SERVICES

PATIENT DETAILS (print clearly - no labels)

NHS No (must be completed)_____

Surname:_____First name:_____Title:_____DOB:_____

Address:_____

Post Code:_____ Tel. No:_____ Sex: M / F Civil State: M/S/W/D

Current Location:_____ Tel. No:_____

Lives alone: YES / NO Religion:_____Ethnicity:_____ Occupation:_____

REFERRAL FOR

Inpatient palliative care unit/Hospice ☐ Specialist Palliative Day Therapy ☐ Bereavement Service ☐

Is the patient known to any community or hospital Specialist Palliative Care Team? YES / NO
If YES, please state: _____

First Language: _____ Is the patient aware of referral? YES ☐ NO ☐

Has the patient had any recent:

Confusion	YES ☐	NO ☐	History of falls	YES ☐	NO ☐
MRSA	YES ☐	NO ☐	Loose stools	YES ☐	NO ☐
CPE	YES ☐	NO ☐			

DISEASE STATUS

Diagnosis: _____

Date of diagnosis: _____ Is the patient aware of diagnosis? YES ☐ NO ☐

Metastases/complications: _____

Disease stage: **early / advanced** Past/current treatments: _____

_____

Patient's understanding of diagnosis/prognosis: _____

Carers understanding of diagnosis/prognosis: _____

REFERRING PERSON (please print)

Name _____ Designation: _____

Signature: _____ Date: _____

Contact no: _____ Ward/Practice:_____

PATIENT NAME: **DOB:**

ADVANCE CARE PLANNING

Has the patient?	A statement of wishes including preferred place of care	YES ☐	NO ☐
	Advance decision to refuse treatment	YES ☐	NO ☐
	Nominated a lasting power of attorney	YES ☐	NO ☐

If so, please give further details:_____

_____

NEXT OF KIN/CARER DETAILS

Full name: _____ Relationship: _____ Tel. No: _____

Address: _____

_____ Post Code: _____

PROFESSIONALS INVOLVED

Consultants and hospitals:_____ GP and contact details: _____

_____ _____

_____ _____

Name and contact details of other professionals (Clinical Nurse Specialists, District Nurses etc)

_____

_____

_____

Please send completed forms to:

Wakefield Hospice
Aberford Road
Wakefield WF1 4TS
Tel: 01924 331400
Fax: 01924 362769