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| **HOSPICE JOINT REFERRAL INFORMATION**  Effective from November 2014 | | | |
| **Marie Curie Hospice** Marie Curie Drive Newcastle upon Tyne, NE4 6SS  Tel: 0191 219 1000 / Fax: **0191 219 1099** | | **St Oswald’s Hospice**, Regent Ave, Gosforth Newcastle upon Tyne, NE3 1EE  Tel: 0191 285 0063 / Fax: 0191 **246 9072** | | |
| **PERSON TAKING REFERRAL:** | | **REFERRAL DATE:** | | |
| **PATIENT DETAILS:**  Name (inc title):  DOB: Age: Sex: M F  NHS No:  Main address:  Post code: Tel:  Ethnic Origin: Religion: | | **REFERRER DETAILS:**  Name: Profession:    Address:  Tel:  Post code: | |
| **GP:**  Address:  Tel: Post code: | |
| **Living Alone? Yes / No**  **Main Carer** (name and relationship) | | **PROFESSIONAL SUPPORT:**  Name: Place: Type:  *Con McM DN*  *Con McM DN*  *Con McM DN* | |
| **Temporary address:** Hospital:  Ward: | |
| **What is the diagnosis?** | | | |
| **Which service is needed?**  1. Inpatient: - Symptom control 2. Outpatient: - Medical 3. Domiciliary visit  - End of life - Lymphoedema 4. Day Hospice  - Planned respite admission (MCHN) - Cognitive therapy 5. Day Treatment -  - Rehabilitation / Readaptation - Acupuncture infusion/transfusion  - Social breakdown/crisis - Hypnotherapy 6. Pt Education & Support  - Complementary therapy a. Positive Steps (SOH)  - Rehabilitation b. Living Well (MCHN) | | | |
| **How soon is the service needed? 🞎** Immediately *(within 24hrs - phone to discuss)* **🞎** 2-5 days **🞎** > 5 days | | | |
| **Problems:**  Pain Nausea / vomiting  Breathlessness  Psychological  End of life care  Lymphoedema  Other (including social breakdown): | | | |
| **Reason for referral / specialist palliative needs** Please include any recent significant events / treatment: | | | |
| **Medication & dose:** | | | |
| **Extra information / requirements:**  Oxygen  Feeding pump  Spinal Line  Specialist equipment eg Alternating Mattress / Bariatric bed / NIV  Pressure sore *(grade & location):* | **Infection Control**  Infection:  MRSA TB Norovirus C Difficile  Other *(please specify):*  Diagnosed / Suspected / Exposure  Symptomatic Yes / No  *Please specify* | | **Special Instructions**  **Has this patient one of the following:**  Current DNAR form?  Advance Care Plan (ACP)/ Advance Decision to Refuse Treatment (ADRT)?  Deprivation of Liberty/Safeguarding Issues |