|  |
| --- |
| **HOSPICE JOINT REFERRAL INFORMATION**Effective from November 2014 |
| **Marie Curie Hospice** Marie Curie Drive Newcastle upon Tyne, NE4 6SSTel: 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 FNHS 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 / ExposureSymptomatic 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 |