Katharine House Hospice

Confidential Referral Form

Patient Name:.....
DOB:.....

Referrer Details

Name of referrer	Referrer Contact Details	Date	Professional Group
			GP DN CNS Hospital Other:

Patient Details

First Name:					**Surname:**	
DOB:			**Age:**		**NHS no.**	
Address:					**Telephone:**	
					Mobile:	
Post Code:					**Ethnicity:**	
					Religion:	
Martial Status:	**Single**	**Married**	**Divorced**	**Widow**	**Occupation:**	
	Partner					

Main Carer:		**Address:**	
Relationship		**Telephone:**	
Next of Kin:(if different)		**Address:**	
Relationship		**Telephone:**	

Main Diagnosis:		**Date of diagnosis:**	
Other Diagnoses:		**Known Allergies:**	

GP: **Practice:**		**DN:** **Base:** **Telephone**	
		CNS: **Base:**	
Telephone:		**Telephone**	

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Main Diagnosis:

If cancer:			
Site of metastases:			
Previous surgery:			
Operation:		**Dates:**	
Consultant:		**Hospital:**	
Chemotherapy:			
Agent:		Date commenced:	
		Date ended:	
		Date commenced:	
		Date ended:	
		Date commenced:	
		Date ended:	
Consultant:		Hospital:	
Continue on a separate sheet if needed			
Radiotherapy:			
Site:		**Date commenced:**	
Reason:		Date ended:	
Site:		**Date commenced:**	
Reason:		Date ended:	
Site:		**Date commenced:**	
Reason:		Date ended:	
Consultant:		Hospital:	

If non -cancer:			
Consultant:		Hospital:	
Clinical Nurse Specialist:		Contact Details:	
Any further information:			

Does this patient have signs or symptoms of / or previous history of: (circle as appropriate)					
MRSA	**Yes**	**No**	**Clostrium difficile**	**Yes**	**No**
Other infection (please specify) **:**					

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Reasons for referral	**Further Details**		
Symptom Control			
Please circle <u>which service</u> you believe would be most appropriate:	In Patient Unit	Lymphoedema	Day Therapies
Emotional /psychological support			
Please circle <u>which service</u> you believe would be most appropriate:	In Patient Unit		Day Therapies
Assessment			
Please circle <u>which service</u> you believe would be most appropriate:	In Patient Unit		Day Therapies
Support for Carers			
Please circle <u>which service</u> you believe would be most appropriate:	In Patient Unit - Crisis Respite or Planned Respite	Respite for Carers	Day Therapies

Well Being Day	A six week programme in self management of fatigue, breathlessness and anxiety. Support and practical advice for coping with the challenges of illness. Every Thursday 09:30 to 15:00. Please use separate referral form available at: https://www.khhospice.org.uk/care/well-being-day

End of Life Care (last week of life) Please circle <u>which service</u> you believe would be most appropriate:	**In Patient Unit**	**Hospice at Home** to make a referral please ring **07966502551** 08:00 -20:00 Mon - Sun Please **do not** send in this referral form - all referrals taken by phone

Urgency of referral:	**Same day**	**2 -3 days**	**Within 7 days**
Estimated prognosis:	**Days**	**Weeks**	**Months**

Is patient aware of referral:	**No**	**Yes**	
Is Carer aware of referral:	**No**	**Yes**	

DNAR discussed with:			
Patient	**No**	**Yes**	**Date:**
			By whom:
Family	**No**	**Yes**	**Date:**
			By whom:

Essential Information to be sent with the Referral:

Current list of medications	
Results of recent investigations (Scans, Xrays, Blood Tests, Histology results)	
Recent hospital letters	

Please Fax the Referral Form to:

01785 270839

If you wish to discuss a patient's suitability for referral, please contact the Medical Director, Director of Care Services or Matron. Telephone 01785 270802

All new referrals will be reviewed and responded to within one working day of referral.

If an ambulance is required the referrer will be asked to arrange this.

Please complete the referral form as fully as possible to enable a prompt decision to be made.

For Hospice Use Only

Initial Contact Date:		**Time:**	
Outcome:			

Referral not proceeding: **Date:**

Reason:

- **Inappropriate -does not meet referral criteria**
- **Out of Area**
- **Not discharged from hospital / died before discharge**
- **Patient / family request**
- **Other**