

ALL WALES SPECIALIST PALLIATIVE CARE TEAM REFERRAL FORM

Referral to:

What is the urgency of the referral? **Urgent (within 48hours)** **Routine**
Urgent referrals include for example severe uncontrolled physical symptoms or ICP for last days of life in place
Routine referrals can be seen within a timeframe guided by the local policy of the team receiving the referral.

REGISTRATION DETAILS [Items marked with * are **mandatory** to enable correct and prompt registration]

*Surname	*Unit No./ NHS No.	*Referring medical lead (i.e. GP/ Consultant)	*GP Name:
*Forename	*DoB	Is Medical Lead aware? <input type="checkbox"/>	*Practice:
*Address		(NB. Referrals can be made by any clinical member of MDT but medical lead must be in agreement)	Tel:
Post Code	*Tel:	Consultants involved	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Carer Name and Relationship:	
Contact Tel Number:			

Current Location, if not at home (please give details):

Hospital: **Ward:** **Other:**

<p>*DIAGNOSIS (please give dates if known)</p> <p>Cancer: Primary site: Secondary site(s):</p> <p>Non Cancer :</p>	<p>* What has the patient been told about the diagnosis & prognosis?</p>
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<p>IMPORTANT Is there a risk for the lone visiting clinician? Yes / No (if Yes, please tell us in the Main Problems section)</p>	<p>* Is the patient aware of the referral? Yes / No (if No, please tell us why you have not made the patient aware in the Main Problems section)</p>
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Main Problems (please include relevant physical, social and / or psychological issues, current medication and purpose of referral.)

Pls continue on separate sheet marking 'page 2/2' etc

<p>SPECIAL CONSIDERATIONS FOR COMMUNICATION REQUIRED? (eg eye-sight, hearing, cognition, language)</p>	<p>SPEC PALL CARE SERVICE REQUIRED ✓</p> <p>COMMUNITY TEAM <input type="checkbox"/></p> <p>HOSPITAL TEAM <input type="checkbox"/></p>	<p>DAY SERVICE</p> <p>MEDICAL OPD <input type="checkbox"/></p> <p>CONSIDER FOR ADMISSION <input type="checkbox"/></p>
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<p>ANYTHING ELSE WE NEED TO KNOW?</p>	<p>INDICATE WHICH HEALTH PROFESSIONAL (S) ✓</p> <p>MEDICINE <input type="checkbox"/> NURSING <input type="checkbox"/> OCC THER <input type="checkbox"/></p> <p>PHYSIO <input type="checkbox"/> OTHER <input type="checkbox"/></p>
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*REFERRER'S NAME	SIGNATURE:	ROLE:	CONTACT TEL: BLEEP NO:	DATE:
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ADMIN ONLY	DATE RECEIVED	DATE REGISTERED	PROFESSIONAL
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