Saint Michael's Hospice

NHS
Harrogate and District
NHS Foundation Trust

# PALLIATIVE CARE REFERRAL FORM

**Referrals can be made electronically via SystmOne, by phone or email**
**All urgent referrals should be made by phone**

## 1. Palliative Care Team

Hospital ☐
Community ☐

**Tel: 01423 553464**

**Electronic referrals accepted via SystmOne or email: hdft.palliativecareteam@nhs.net**

## 2. Saint Michael's Hospice

Inpatient unit (GPs and PCT only) ☐
Day Therapy Unit ☐
Palliative Lymphoedema Clinic ☐
Neurological Conditions CNS ☐
Volunteer Visitor Service ☐
Physiotherapy (internal referrals only) ☐
Occupational Therapy (internal referrals only) ☐
Social Work (internal referrals only) ☐
Spiritual/pastoral service (internal referrals only) ☐

**Electronic referrals accepted via SystmOne**

**Routine referrals** **Tel: 01423 879687**

**Urgent referrals only** **Tel: 01423 872658**

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|---|---|
| Patient Name:<br><br>Prefers to be called: | NHS no:<br><br>Hospital no: |
| Address: | Date of birth:<br><br>Telephone:<br><br>Mobile no: |
| Key code: | Lives alone: Yes / No |
| Does the patient have communication issues? Yes/No<br>If yes, what are they? | |
| Current location of Patient:<br>Home ☐<br>HDFT ☐ Ward _____ Date of admission _____<br>Other Hospital ☐ Location _____<br>Care Home ☐ Name _____ | |
| NOK/contact name:<br>Relationship:<br>Telephone number:<br>Is this person Next of Kin? Yes/No<br>Main Carer? Yes/No | GP:<br>Surgery:<br>Tel:<br><br>Nursing/other care teams involved: |
| Has patient consented to referral? Yes/No | |

| Is relative aware of referral? Yes/No | |
|---|---|

| Diagnosis, treatment & relevant medical history: |
|---|
| **MAIN CONCERNS - REASON FOR REFERRAL** (referrals can be for physical, psychological, social and spiritual problems): |
| Continue on separate sheets ☐ |
| Is a DNACPR in place? Yes / No |
| **Saint Michael's Hospice referrals ONLY:**<br>Detail any supportive interventions e.g. PEG feeding, NIV, oxygen (NB if on oxygen specify L/min)<br><br>If patient smokes are they aware that they cannot smoke within the hospice building? YES / NO / N/A<br>Level of mobility (e.g. aids used):<br>Access to patient's home (e.g. steps, flat, multi-level etc): |

| Name of referrer: | Date of referral: |
|---|---|
| Position: | Contact no: |

| Date / time referral received: | By: | Signature: |
|---|---|---|
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