

FORM FOR REFERRAL TO HOSPICE SERVICE



St. Andrew's Hospice
Henderson Street, Airdrie ML6 6DJ

Telephone: 01236 766951

Fax: 01236 748786

Website: www.st-andrews-hospice.com

Patient Details:	CHI No.:	Patient aware of Referral <input type="checkbox"/>
Surname:	Forenames:	
Address:	Tel. No.:	
.....	Post Code:	
Date of Birth:	Age:	Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep <input type="checkbox"/>

Is the patient at home: <input type="checkbox"/>	Hospital: <input type="checkbox"/>
Has the patient been referred to	Under the care of:
St. Andrew's Hospice before: Yes <input type="checkbox"/> No <input type="checkbox"/>	Ward:

Main Carer/Next of Kin:	Main Carer aware of Referral <input type="checkbox"/>
Surname:	Forenames:
Address:	Tel. No.:
.....	Post Code:
Relationship:	
Please specify who initial contact should be with: Patient <input type="checkbox"/> Main Carer/Next of Kin <input type="checkbox"/>	

Referrals will be considered for patients in need of Specialist Palliative Care
Date of Referral:

Request for:	<i>Please tick relevant boxes</i>
Inpatient - Symptom Control <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Terminal Care <input type="checkbox"/>	
Day Services <input type="checkbox"/> Symptom Control <input type="checkbox"/> Psychological Support <input type="checkbox"/> Outpatients <input type="checkbox"/>	
Hospice Care at Home <input type="checkbox"/>	

**If the patient needs to be assessed within 48 hours,
please telephone St. Andrew's Hospice and speak to Consultant on-call.**

Medical Information *(Confidential)*

To be completed by the referring Doctor

Diagnosis: Date of Diagnosis:

Histology if known:

Known Metastatic Sites: Other Medical Conditions:

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Has the patient been fitted with: Pacemaker: Yes No Radioactive Implant: Yes No

Results of recent Investigations:

Please state date and location

F.B.C.:

U. & E.'s:

X-rays/Scans:

Other:

Hospital Treatment:

Please state if none

Surgical Operations:	Consultant	Hospital	Hosp. No.	Date
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Radiotherapy/Chemotherapy:

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Other Treatments:

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Follow up Appointments and Dates:

Consultant	Hospital	Date
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Name of General Practitioner:

Address:

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Tel. No.: Fax No.:

Social Support Services in the Care of the Patient:

Macmillan Nurse (Hospital) Macmillan Nurse (Community) District Nurse

Name: Name: Name:

Daycare:

Location:

Family/Social History:

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Other relevant information:

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Has General Practitioner or Consultant approval been given for this referral: Yes No

Referrals will not be considered without General Practitioner (*for patients in the community*)
or Consultant (*for inpatients*) permission

Signature of Referrer:

Name:

Designation:

Address:

Tel. No.: Fax No.: Page No.: