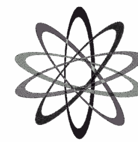
Wakefield Metropolitan District
Specialist Palliative Care Services
Patient Referral Form



Patient details: (print clearly – no labels)

Hospital No: ……………………………… NHS No: …………………… Hospice No: ……..……………

Surname: ………………………………… First name: …….………….. Title: ……... DOB: ……………

Address: ……………………………………………………………….... Age: …………… Sex: M / F

……………………………………………. Post code: ……………….… Tel No: ……………….………..

Current location: ………………………………………………………….. Tel No: …………………………..

Lives alone: YES/NO Marital Status: …………….

Religion: ……………………… Ethnicity: …………………….. Occupation: …………………………………..

Next of kin / carer details:

Full name: ……………………………… Relationship: ……………….. Tel No: ………………………………

Address: ………

…………………………………………………………………………… Post code: ……………………….…

NoK contact (if different): ………………………………………………………………………………....

Disease status:

Diagnosis: ………………………………………………….. Date of diagnosis: ……………………………

Spread/complications:…………………………………………………………………………………….

……………………………………………………………………(Disease stage: **early/advanced)**

Past/current treatments: ……………………………………………………………………………………

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Patient's understanding of diagnosis / prognosis: ………………………………………………………….

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Carers understanding of diagnosis / prognosis: ...…………………………………………………………

Is patient aware of referral: Yes No

Professionals involved:

Consultant(s) and hospital:…….. GP:…………………….…… D/N:……………………………………

……… …………………………… Tel: ………………………….. Tel: …………………..………………

…………………………………… Address: …………………… Address: ……………………………..…

………….……………………… ………………………………… …..………….……………………………..

PCT…………………………

Clinical Nurse Specialists ………………………………………………………………..………………

Social Services name and Tel No: …….…………………….…… Other: ………..……………………

PTO

Patient Name: **DOB:**

Specialist Palliative Care Needs

Please state as fully as possible the main problems that have led to the request for specialist palliative care assessment. Include relevant information on physical symptoms (including mobility), carers needs, psycho-social/spiritual issues and difficult ethical needs as appropriate.

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What service do you feel your patient currently requires? (Indicate one or more options)

1	Patient assessment home	2	Specialist Palliative Day Therapy
3	Patient assessment hospital	4	Inpatient palliative care unit/Hospice
5	Outpatient appointment	6	Lymphoedema Care
7	Bereavement Service	8	Patient assessment Care Homes
9	Complementary Therapy	10	Physiotherapy

Referral priority: (please tick)
High (severe symptoms, crisis intervention)-if referral is High priority, please ring the appropriate office
Medium (symptom control, emotional needs)
Low (planned care)

Referring person

Name: (please print) ……………………………………… Designation: ………………………………………

Signature: ……………………………………………….. Date: ……………………………………………

Contact no: ……………………………………………….. Ward………………………………………………..

(Signature confirms approval of patient's GP or Consultant)

For specialist palliative care assessment please send completed forms to appropriate location

Department of Palliative Medicine:

Pinderfields General Hospital/Wakefield Community Team	☎ 01924 212290	Fax: 01924 212849
Pontefract General Infirmary	☎ 01977 606530	Fax: 01977 606530
Macmillan Palliative Care Team, Pontefract	☎ 01977 606013	Fax: 01977 606029
Clinical Nurse Specialist for Care Homes	☎ 01977 606013	Fax: 01977 606029
Prince of Wales Hospice, Pontefract	☎ 01977 708868	Fax: 01977 600097
Wakefield Hospice	☎ 01924 213900	Fax: 01924 362769 /01924 214019

Referral Priority: Routine/Urgent

Date Received: …………………………Date of First Contact: …………………… PCT No: …………………..