

DATE REFERRAL RECEIVED	DATE OF FIRST CONTACT	DATE OF ASSESSMENT	DATE OF ADMISSION
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The Mary Stevens Hospice
 221 Hagley Road
 Oldswinford
 Stourbridge
 West Midlands DY8 2JR
 Tel: 01384 443010 Fax: 01384 373731

REFERRAL FORM

Patient's Surname: (block capitals please) Forenames:

Sex M / F Date of Birth: Age: Marital Status: (M/S/W/D)

Present Address:

..... Post Code: Tel No:

Hospital In-Patient: Yes No Hospital No:

Hospital: Hospital Ward:

PLEASE TICK THE MOST APPROPRIATE CATEGORY

What is the Referral For? Day Care Admission

If admission, is it for: Booked Respite Symptom Control Terminal Care

Is the referral urgent? Yes No (if urgent, please state what factors contribute to its urgency)

Main Carer

Name: Relationship:

Address:

Tel No. Daytime: Night time:

General Practitioner

Name: Tel No. Fax No

Address:

IS GP AWARE OF REFERRAL?

Consultants

1. Name: Hospital:

2. Name: Hospital:

IS CONSULTANT AWARE OF REFERRAL?

Other Health Care Professionals

District Nurse: Tel No.

Macmillan Nurse: Tel No.

Medical Information (please give full details of History and Treatment, including histology & site of mets)

Diagnosis:

Date of Diagnosis: Prognosis:

Investigations / Operations:

Who has stated this prognosis and when was it given?

Insight – what does the patient and their families know of his/her illness?

Treatment; Please detail all treatment received e.g. Radiotherapy – Chemotherapy – Hormone Therapy etc.

Received

Planned

Current Drugs (including doses)

Current Symptoms:

Past medical / psychiatric history:

DATE LAST SEEN BY REFERRING PERSON:

Please Note: For this referral to be processed we must have copies of any current medical correspondence which may be relevant, such as consultant letters and histology reports.

Name & position of referring Health Care Professional:

Signature: Date:

Tel: Fax:

Name of Referring PCT:

The Hospice invoices PCTs outside of the Dudley area for 50% of unit costs per day for each patient episode as a contribution towards the cost of service provision.

Any Further Comments:

Who Can Be Referred

The Hospice will consider the referral of patients aged 17 years or more with advanced cancer and patients with motor neurone disease, HIV / AIDS and other progressive, advanced incurable illnesses with specific palliative care needs.

Referrals will include patients with physical, psychological, social or spiritual needs.

For example:

- Patients with complex symptom control issues
- Patients who need psychological support for themselves or their family
- Patients who are experiencing a rapid deterioration and frequent changes in their disease.

The Referrer

A Hospital Consultant or the patient's General Practitioner may make referrals.

All GP's are informed of the referral of their patient if made by a Consultant and their approval and advice is sought.

Other members of the Health Care Team and sometimes non-health care professionals prompt many referrals. It is essential for the work of the Hospice that the referral has the knowledge and support of the patient's GP and Consultant and therefore all such referrals must be made in liaison with the patient's doctor.

**Return to the Medical Secretary at Mary Stevens Hospice by Post or Fax.
Clearly identified as confidential**

Thank you for the referral, your involvement is needed and appreciated; visits to the hospice are welcomed.