|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | **Title** | **Forenames** | **Surname** | **Preferred name** |
| **DOB** | **Age** | **Gender** | **NHS no.** | **Marital****status** | **Ethnic origin** | **Religion** | **Main language** | **Interpreter required** **Y/N** |
| **Current address****Post Code** | **Email address** | **Contact no.**  **Day Time:**  **Evening:** **Mobile:** |
| **Current location****Home Hospital Other (specify)****Contact no.** **(if different from above)** | **Diagnosis** | **Prognosis****Years Months Weeks Days** |
| **REFERRER** | **Title** | **Forenames** | **Surname** |
| **Contact no.**  | **Email address** | **Date last seen by referrer** |
| **REASON** **FOR** **REFERRAL** | **Symptom Control** | **End of Life Care** | **Respite** | **Day Services** | **Bereavement Support** |
| **Supporting information**  |
| **GP** | **GP** | **Practice** | **Contact no.** | **Email address** |
| **Hospital** | **CCG** | **Is patient on GP Palliative Care Register** **Y/N** |
| **NEXT OF** **KIN/CARER** | **Title** | **Forenames** | **Surname** | **Relationship** |
| **Address** |
| **Post Code** | **Contact no.** |
| **AUTHORISATION** | **Is patient aware of the referral and agrees to participate in information being shared Y/N****If No, please supply a reason** |
| **FUNDING** | **Has funding been agreed? Yes or No Only applicable if outside Dudley CCG** |



**PLEASE RETURN FORM TO - marystevens.hospice@nhs.net**

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**MARY STEVENS HOSPICE - REFERRAL FORM**