|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT DETAILS** | **Title**   | **Forenames** | **Surname** |
| **Preferred Name** | **Preferred Pronoun** |
| **DOB** | **Age** | **Gender Identity** | **NHS no.** | **Marital****status** | **Ethnicity** | **Religion** | Spoken language: |
| Interpreter required: |
| **Home address (inc. postcode)** | **Contact No.** **Day:** **Evening:****Mobile:** |
| **Current Location** |
| **Home** |  |
| **Contact No.** |  |
| **Hospital** | **Ward** | **Ext.** |
| **Other** |  |
| **NEXT OF KIN****or****KEY CONTACT** | **Title** | **Forename/s** | **Surname**  |
| **Address (inc. postcode)****Telephone No.**  | **Relationship****Is Next of Kin / Key Contact first point of contact?**  |
| **Yes** |  | **No** |  |
| **GP** | **Name** | **Practice Address** | **Contact No.** | **Email address** |
| **DIAGNOSIS****&****REASON FOR REFERRAL** | **Diagnosis** |
| **Prognosis** | **Is patient aware of diagnosis / prognosis?**  |
| **Years** |  | **Months** |  | **Weeks** |  | **Days** |  |
| **DNACPR** |  | **ReSPECT** |  | **Infection/s** |  | **Allergies** |  |
| **Relevant Past Medical History** |
| **Symptom Management** |  | **Crisis Intervention** |  | **End of Life Care** |  | **Day Therapies** |  |
| **Additional information** |
| **REFERRER** | **Name** | **Role** | **Contact No.** | **Date last seen by Referrer:** |
| **AUTHORISATION** | **Has this referral been discussed with the patient?** | **Yes** |  | **No** |  |
| **If No, is the Next of Kin / Key Contact aware?** | **Yes** |  | **No** |  |
| **FUNDING** | **Has funding been agreed?** **Only applicable if outside Dudley CCG** | **Yes** |  | **No** |  |



**PLEASE RETURN FORM TO -** care.stourbridge.marystevenshospice8c717@nhs.net

**221 Hagley Road, Stourbridge, West Midlands DY8 2JR Main switchboard: 01384 443010**

**MARY STEVENS HOSPICE - REFERRAL FORM**