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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**