|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | **Please email to:** | |
|  | | | | | | | [**ggc.svh@nhs.scot**](mailto:ggc.svh@nhs.scot) | |
|  | | | | | | | **Clinical Administration** | |
|  | | | | | | | **St. Vincent’s Hospice** | |
|  | | | | | | | **Midton Road, Howwood** | |
| **St. Vincent’s Hospice** | | | | | | | **Renfrewshire, PA9 1AF** | |
| **Referral Form** | | | | | | | **Tel: 01505 705 635** | |
| **Medical - In Confidence** | | | | | | |  | |
| **Referrals cannot be accepted if information on this form is incomplete** | | | | | | | **Hospice Case Record No:** | |
| **Patient Information** | | | | | | | | |
| Name: |  | | | | | | DOB: |  |
| Address: |  | | | | | | CHI No: |  |
|  |  | | | | | | Marital Status: |  |
| Postcode: |  | | | | | | Tel No: |  |
| Ethnicity: |  | | | | | | Religion: |  |
| **Main Carer/Next of Kin Details** | | | | | | | **Patient’s GP** | |
| Name: |  | | | | | | Name: |  |
| Relationship to Patient: | | | |  | | | Address: |  |
| Address: |  | | | | | |  |  |
|  |  | | | | | | Postcode:: |  |
| Postcode: |  | | | | | | Tel No: |  |
| Tel No Day: |  | | | | Night: |  |  | |
| **Diagnosis** | | | | | | | **Hospital Consultant(s)** | |
| Primary: |  | | | | | | Name: |  |
| Date of Diagnosis: | |  | | | | | Hospital: |  |
| Site(s) of Secondaries: | | |  | | | | Name: |  |
|  |  | | | | | | Hospital: |  |
| **Investigations & Treatment** (please attach relevant correspondence)**:** | | | | | | | | |
| **Past Medical History:** | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient informed of diagnosis: Yes  / No** | | | | | | | | | **Patient aware of referral: Yes  / No** | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | |
| **Service Required:** (please check appropriate boxes) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Consultant Review:- | | | As Outpatient | | | |  | | | CNS Assessment | | | | | | | |
|  | | | At Home | | | |  | | | (Clinical Nurse Specialist – Community) | | | | | | | |
|  | | |  | | | | |  | | | | | | | | | |
| Inpatient Unit Admission | | | | | | Day Hospice Place | | | | | | | Bereavement Support | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Referral for Physiotherapy and Occupational Therapy to be made through the Community Nurse Specialist** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Reason for Referral:** | | | Symptom Control | | | | | | | Respite | | | | | End of Life Care | | |
|  | | |  | | | | | | |  | | | | |  | | |
| **Patient Currently:** | | At Home | | | | In Hospital: | | | | | | | | | | | Ward: |
|  | |  | | | |  | | | | | | | | | | |  |
|  | | Nursing Home: | | | | | | | | | | | | | Tel No: | | |
| **Please enclose a copy of the completed Carenap** | | | | | | | | | | | | | | | | | |
| **Current Medication:** | | | | | | | | | | | | | | | | | |
| **Allergies:** | | | | | | | | | | | | | | | | | |
| **Please select score describing your patient using the following 0 – 4 guide:** | | | | | | | | | | | | | | | | | |
| **Pain** | | | | | **Symptom** (specify) | | | | | | **Symptom** (specify) | | | | | | |
| **Symptom** (specify) | | | | | **Mobility** | | | | | | **Family Anxiety** | | | | | | |
| **Care Environment** | | | | | **Spiritual Distress** | | | | | | **Please note a low score does not necessarily mean your patient will not be a priority admission**  **Adapted from STAS**  **(Support Team Assessment Schedule)** | | | | | | |
| **Total Score:** | | | **IF REFERRAL IS URGENT PLEASE MAKE DIRECT CONTACT BY PHONE** | | | | | | | | | | | | | | |
| **Signature of Referrer:** | | | |  | | | | | **Designation:** | | | | |  | | | |
| **Address:** |  | | | | | | | | | | | **Date:** | | | |  | |