|  |  |
| --- | --- |
|  | **Please email to:** |
|  | **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:** |       |