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|  | **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** |  |
| **Clinical - In Confidence** | **Tel: 01505 705 635** |
| **Referrals cannot be accepted if information****on this form is incomplete** |  |
| **Referral Status:**  [ ]  **SAME DAY RESPONSE (please call to discuss)** [ ]  **URGENT (2 day response)**  [ ]  **ROUTINE (4 day response)**  **Service Required:**  In-Patient Unit admission for : EOLC[ ]  Symptom Control[ ]  Assessment[ ]  Respite[ ]  Community (medical and/or specialist nurse) assessment – Home[ ]   Supportive Care Clinic[ ]  Day Services[ ]  Bereavement Counselling[ ]  Family Support[ ]  **Please can you confirm you have informed the patient and family of referral** : YES[ ]   |
| **Name of referrer:**Click or tap here to enter text. **Designation:** Click or tap here to enter text.**Contact No:**  Click or tap here to enter text. **Email:** Click or tap here to enter text.**Date:** Click or tap here to enter text. |
| **Patient Details** Name: Click or tap here to enter text. Address:Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text. Post Code:Click or tap here to enter text. Telephone:Click or tap here to enter text. DOB/CHI:Click or tap here to enter text. | **Patient Information**Current location: Home [ ]  Hospital [ ]  Other [ ]  Do they live alone? Yes [ ]  No [ ]  |
|  **Main Carer/Next of Kin**  Name:Click or tap here to enter text. Relationship to patient:Click or tap here to enter text. Phone no: Click or tap here to enter text. POA? YES[ ]  NO[ ]   |  **GP Practice and Hospital Consultant** GP & Practice:Click or tap here to enter text. Phone no:Click or tap here to enter text. Consultant:Click or tap here to enter text. Hospital:Click or tap here to enter text. |
|  **Please see next page to provide SBAR/Handover**  |
| **Diagnosis*** Main diagnosis: Click or tap here to enter text.
* Diagnosis Date:Click or tap here to enter text.
* Other Diagnoses: Click or tap here to enter text.

Click or tap here to enter text.Click or tap here to enter text.Click or tap here to enter text.**Are the patient and their family aware of diagnosis? YES**[ ]  **NO** [ ]  |
| **Situation**(briefly state the current situation and relevant factors)**-------------------------------------------------------------------------------------------------------------**Click or tap here to enter text. |
| **Background**(pertinent information related to the situation)**-------------------------------------------------------------------------------------------------------------**Click or tap here to enter text. |
| **Assessment**(Summarise the facts and give your best assessment as to what is going on)**-------------------------------------------------------------------------------------------------------------**Click or tap here to enter text. |
| **Recommendation**(What action are you asking for? What do you hope to happen next?)**-------------------------------------------------------------------------------------------------------------**Click or tap here to enter text. |

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| **Current Medication:** Click or tap here to enter text.Click or tap here to enter text.Click or tap here to enter text.**Allergies:**Click or tap here to enter text. |