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|  | **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** |  | |
| **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. |