w ASHGATE HOSPICECARE PALLIATIVE CARE SPECIALIST NURSE TEAM

Please tick whether this is an Urgent or a Routine referral to the Hospice:
URGENT (1-2 working days) ☐ **ROUTINE** (7 working days) ☐
If the referral is URGENT please state reason why:

(Please see Criteria for further information)

GUIDANCE: Please complete all relevant sections below. Please email completed form and relevant documentation to:
ashgateCnstriage@nhs.net **Fax: 01246 565027**
REFERRALS WILL NOT BE ACCEPTED IF INFORMATION REQUESTED IS NOT COMPLETED OR IF THE PATIENT REFUSES TO CONSENT.

Date of referral:	**Name of referrer:** **Job Title:**	**Base of work:**
Email:	**Contact telephone:**	
Referrer's availability to be contacted:		

HAS THE PATIENT CONSENTED TO THE REFERRAL AND AGREED TO SHARE THEIR HEALTH RECORDS?
YES ☐ **NO** ☐

Is the District Nurse involved in the patient's care? Yes ☐ **No** ☐
If No, please make a referral to the District Nursing Team.

Has the patient been known previously to Ashgate Hospicecare? Yes ☐ **No** ☐
If yes please state which services:

Patient's current location?

PATIENT DETAILS

Name of patient		
NHS number:	**Date of birth:**	**Age:**
Address:		

Contact Tel:	**Mobile:**
Is English their first language? Yes ☐ **No** ☐ **If No, what is their preferred language?** **Ethnicity**: **Marital Status**:	**Does the patient live alone? Yes** ☐ **No** ☐ **Key Safe**: **Religion**:
NEXT OF KIN/PREFERRED CONTACT	**OTHER RELEVANT FAMILY MEMBER**
Name: **Relationship**: **Address:** **Contact Tel**: **Mob**:	**Name**: **Relationship**: **Address**: **Contact Tel**: **Mob**:

GP AND DISTRICT NURSING TEAM

Named GP: **Surgery**: **Tel**: **Is GP aware if referral? Yes** ☐ **No** ☐	**District Nurse**: **Tel**: Please refer to the District Nursing Team if you have not already done so.

OTHER PROFESSIONALS INVOLVED

Name of Hospital Consultant: **Base**: **Contact Tel**:	**Additional Professional if known**: **Base**: **Contact Tel**:
Palliative Care Consultant/CNS:	**Social Services involved? Yes** ☐ **No** ☐ **Unknown** ☐ **Care Manager**:

DIAGNOSIS, TREATMENT AND PAST MEDICAL HISTORY

Primary(ies) Diagnosis:
Date of Diagnosis:

Metastases:
Date of Diagnosis:

Past Medical History:

Allergies: Yes ☐ **No** ☐ **Unknown** ☐ **If yes, please state:**

PLEASE STATE DETAILED REASON FOR REFERRAL INCLUDING CURRENT SYMPTOMS:

Is the Patient currently having any treatment/investigations?:

Does the Patient have any mobility, disability, communication/language issues?:

Has a DS1500 been completed?
Yes ☐ **No** ☐ **Unknown** ☐

HOME RISK ASSESSMENT

Are there any hazards in the home?
Yes ☐ **No** ☐ **Unknown** ☐
If yes please state:

Are there any pets in the home?
Yes ☐ **No** ☐ **Unknown** ☐
If yes please state:

Are there any smokers in the home?
Yes ☐ **No** ☐ **Unknown** ☐

Any past episodes of aggression/violence?
Yes ☐ **No** ☐ **Unknown** ☐

Are there any difficult family circumstances?
Yes ☐ **No** ☐ **Unknown** ☐
If yes, please provide more information:

DOCUMENTATION

Please tick which documentation you have included with the referral:

List of current medication ☐ **Latest clinic letter** ☐ **Latest letter from GP** ☐ **GP Summary** ☐
Past Medical History ☐ **DS1500 Form** ☐

PLEASE NOTE THAT YOU MUST INCLUDE A CURRENT LIST OF MEDICATION AND AT LEAST ONE MORE OF THE ABOVE DOCUMENTATION WITH THE REFERRAL TO BE ACCEPTED AND AVOID DELAY.

Date of discharge	Date/Place of death

Please download this document to your computer and complete electronically.
Referrals can be sent to **ashgateCnstriage@nhs.net**
The referral form, criteria and process can be found at www.ashgatehospicecare.org.uk
Triage Hub: 01246 565026 **Clinical Admin Team:** 01246 565029 **Main Reception:** 01246 568801 **Fax:** 01246 565027
The Triage Hub is open **Monday – Friday 09:00 – 17:00**