Please fax to:
Kilbryde Hospice
McGuinness Way, East Kilbride G75 8GJ
Tel: 01355 202020
Fax: 01355 279616

Patient information	DOB					
Name	CHI No					
Address	Marital status	**M**	**S**	**W**	**DIV**	**SEP**
Post Code	Tel No.					
Email						
Ethnicity	Religion					

Main Carer/NOK details	**Patients GP**
Name	Name
Relationship to patient	Address
Address	
Post code	Post code
Tel No.	Tel No.

Diagnosis	**Hospital Consultant/s**
Primary	Name
Date of Diagnosis	Hospital
Site of Metastases (if applicable)	Name
	Hospital

Investigation & Treatment (please enclose relevant correspondence

Past Medical History (please supply relevant clinic letters)

Patient informed of diagnosis YES / NO Patient consent to referral YES / NO

Service required (please tick as appropriate)

Day Services for physical & psychological support	
Care @ home (psychological support for patients & carers) for housebound patients	
Befriending	

Reason for referral – please state :

Any known risk factors within the home environment:

Patient currently:	
At home	
In hospital	Ward
Care Home	Tel no
Other	

Current Medication

Allergies:

Please score describing your patient using the following 0 – 4 guide:

PAIN			**SYMPTOM**			**SYMPTOM**		
0	None		0	None		0	None	
1	Slight		1	Slight		1	Slight	
2	Moderate		2	Moderate		2	Moderate	
3	Severe		3	Severe		3	Severe	
4	Overwhelming		4	Overwhelming		4	Overwhelming	
Symptom			**Mobility**			**Family anxiety**		
0	None		0	None		0	None	
1	Slight		1	Slight		1	Slight	
2	Moderate		2	Moderate		2	Moderate	
3	Severe		3	Severe		3	Severe	
4	Overwhelming		4	Overwhelming		4	Overwhelming	

STAS (Support Team Assessment Schedule) Criteria

Care Environment		**Spiritual Distress**	
0 Appropriate & suitable for all		0 None	
1 Mildly unsuitable but acceptable		1 Minimal worries, life ok	
2 Moderately unsuitable/distress caused		2 Sometimes troubled, losing control/support needed	
3 Unsuitable / severe distress caused		3 Uncertain, troubled, conflicts & worries, life difficult	
4 Totally unsuitable, Overwhelming distress caused		4 Distraught. Life in chaos, life not worthwhile	
TOTAL SCORE		**Perceived Level of urgency (tick as appropriate)**	
		E = Emergency (24-48 hours) please telephone	
		U = Urgent (within one week)	
		N = Non urgent (within four weeks)	
Signature of referrer:		**Print Name:**	
Designation:		**Date:**	
Contact telephone number :			