|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Patient |  |  | Carer |  |  | Relative |  |  | Child / Young Person |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 - Referred Person | Title |  |  | *Surname* |  |  | *Forename(s)* |  |
|  |
| Known As |  |  | Address |  |
| DOB |  |  |  |  |
| CHI Number |  |  |  |  |
| Ethnicity |  |  | Post Code |  |
| Religion |  |  |  |  |
| Gender |  |  | Home Tel |  |
| Marital Status |  |  | Mobile |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2. First Contact | Name |  |  | Relationship |
| Address |  |  | Relationship |  |
|  | Tick all of the following that apply |
|  | Next of Kin |  |
| Post Code |  |  | Main Carer |  |
| Email |  |  | Additional Carer |  |
| telephone |  |  | Parental Responsibility |  |
| Mobile |  |  | Primary Emergency Contact |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 3. Health Care Processionals & Diagnosis | General Practitioner |  | Hospital Consultants ( patients only)  |
| Name |  |  | Name | Hospital |
| Practice Name |  |  |  |  |
| Address |  |  |  |  |
|  |  |  | CHILD/YOUNG PERSONNAME |  |
|  |  |  | SchoolHead teacher | Addressphone  |
| Post Code |  |  | Health Visitor  | Addressphone |
| Email |  |  | Social Worker | Addressphone |
| Telephone |  |  | OTHER | Addressphone |
|  | Primary Diagnosis (patients Only) | Secondary Diagnosis (patients Only) |
| Diagnosis |  |  |
| Diagnosis Date |  |  |
| Metastases? |  |  |
| Patient Informed of Diagnosis? |  | Person/PARENT/GUARDIAN Consent to Referral? |
| YES |  |  | YES |  |
| NO |  |  | NO |  |

|  |  |
| --- | --- |
| 4. Investigations and Treatments | Investigation and Treatment (Patient only please enclose relevant results ) |
|  |
| PAST MEDICAL HISTORY ( patient only please enclose relevant clinic letters) |
|  |

|  |  |
| --- | --- |
| utpatients | Service Required (Tick as appropriate) |
|  | Outpatients for physical and psychological support |
|  | Carer / Relative Support |
|  | Bereavement Support (for bereaved relatives of Kilbryde Hospice Patients) |
|  | CHILDREN/YOUNG PERSON SERVICE |
|
| Reasons for Referral |  | RISK FACTORS  |
|  |  |  |
|  |
|  |
|  |
| Patient’s Current Location |
|  | At Home |
|  | Hospital (Name & Ward No.) |  |
|  | Other |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 6. Current Condition | Please Tick Appropriate Box. Please add any additional symptoms | **None****(0)** | **Slight****(1)** | **Moderate****(2)** | **Severe****(3)** | **Overwhelming (4)** |
| PAIN |  |  |  |  |  |
| MOBILITY |  |  |  |  |  |
| FAMILY ANXIETY |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 7. URGENCY | **EMERGENCY****(Within 24 Hours)** | **URGENT****(Within one week)** | **NON URGENT****(Within 4 Weeks)** |
| Please Tick Perceived Level of Urgency |  |  |  |

Lou

|  |  |  |  |
| --- | --- | --- | --- |
| 8. Referrer | Print Name |  | **FOR HOSPICE USE ONLY** |
| Designation |  | Date Received |  |
| Contact No. |  | Date Referral Meeting |  |
| Date |  | Decision |  |
| Signature |  | Service |  |