|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 | Daughter | |
|  | 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 PERSON  NAME | | |  |
|  |  |  | School  Head teacher | | | Address  phone |
| Post Code |  |  | Health Visitor | | | Address  phone |
| Email |  |  | Social Worker | | | Address  phone |
| Telephone |  |  | OTHER | | | Address  phone |
|  | 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)** |
|  |  |  |  |  |  |
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| --- | --- | --- | --- |
| 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 |  |