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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1 - Referred Person** | Title |  | Surnam*e* |  | | **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 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) |  | SECONDRY Diagnosis (patients Only) |
| Diagnosis |  | Diagnosis |  |
| Diagnosis Date |  | Diagnosis Date |  |
| Metastases |  | Metastases |  |
| 4.PAST MEDICAL HISTORY (PATIENT only please enclose relevant clinic letters) | | | | |
|  | | | | |

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| --- | --- | --- | --- | --- | --- |
| **5. outpatients** | 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 | | | |
|  | FRAILTY/ befriending service | | | |
|
| Reasons for Referral | | |  | RISK FACTORS |
|  | | |  |  |
| Patient’s Current Location | | | | |
|  | At Home | | | |
|  | Hospital (Name & Ward No.) |  | | |
|  | Other |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Informed of Diagnosis? | | Person/PARENT/GUARDIAN Consent to Referral? | |
| YES |  | YES |  |
|  |  |  |  |
| NO |  | NO |  |

|  |
| --- |
| Investigation and Treatment (Patient only please enclose relevant RESULTS) |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 6. Current Condition | Please Tick Appropriate Box. Please add any additional symptoms | **None**  **(0)** | **Slight**  **(1)** | **Moderate**  **(2)** | **Severe**  **(3)** | **Overwhelming (4)** |
| Mobility |  |  |  |  |  |
| Pain |  |  |  |  |  |
| Family Anxiety |  |  |  |  |  |
|  |  |  |  |  |  |
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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 |  |