Referral Form

Winsley, Bradford on Avon, BA15 2LE
Triage Tel: (01225) 721385 (Secure Fax no longer available)
Referrals email: DHHC.dorothyhouse-referrals@nhs.net
Website: www.dorothyhouse.co.uk/prodownload
Please do not fax this form, send via email (using nhs.net) or post

DOROTHY HOUSE Hospice Care

Surname:	**First names:**

Title	Select		Marital Status	Select		Sex:	Select
DOB:			Occupation Status:	Select			
Address:			Type of Occupation:				
			Patient Lives Alone	☐Yes ☐No			
			RAF: We can currently claim for patients who:				
Post Code			Are currently serving in the RAF:				Yes
Telephone Home:		Select	Have served in the RAF (inc. National Service):				Select
Mobile:		Select	Have a relative who is either current or ex-RAF: ☐Wife ☐Husband ☐Widow ☐Widower (please tick)				Select
Hospital No:							
NHS No:			Ethnic Group:	Select			
☐Unregistered	☐Unknown		Religion:				

Main Carer	Select		**Next of Kin (if different)**			
Name:			Name:			
Address:	Post Code:		Address:	Post Code:		
Telephone:			Telephone:			
Relationship:	Select		Relationship:	Select		
Are they the NOK ☐Yes ☐No		Are there children of <18	Select	If Yes, how many?		

Heath & Social Care Practitioners

Date of Referral (dd/mm/yyyy)		Location of Patient/ Client on Referral	Select		
Referred by		Base			
Position		Telephone			

GP		Hospitals involved	
Practice		Consultants	
District Nurse		Social Worker	
Key Worker		Allied Health Care Professional	

Primary Diagnosis		Date of Diagnosis (dd/mm/yyyy)	
Site/s of Metastases		☐None	☐Unknown
Other Significant Diagnoses?			
Known Allergies?			

Surname:	**First names:**	
Does the patient have:	A life threatening condition	Select
	Complex physical, psychosocial, or spiritual needs	Select
Do the relatives or carers of the patient have related complex needs themselves which require additional specialist support? (Preferably with the knowledge of the patient)		Select

	Specific reason(s) for referral	Further details
☐	Symptom Control	
☐	Emotional/Psychological Support	
☐	Spiritual Support	
☐	Rehabilitation/Readaptation	
☐	Support for Carer	
☐	Advice re Future Management	
☐	Management of Lymphoedema	
☐	Terminal Care	
☐	Inpatient Unit Admission - for **acute admission only, please call** 01225 722999 for further discussion, and complete form	
☐	Hospice at Home (Please complete form and call 01225 722 921 for further discussion)	

Contact Priority			
	☐Urgent (1-2 days)	Is the patient on the End of Life Care Register?	Select
	☐Soon (within 1 week)	Is the patient/client aware of this referral	Select
	☐Routine (within 2 weeks)	Is the GP aware of this referral	Select

Could the patient/client travel as an outpatient? Select	
Are there any risks to lone workers?	Select Comments:
Does the patient have a SystmOne GP record?	Select
If Yes, has consent for sharing patient records been Select	

Further referral information attached:

☐Copy Letters ☐ Results of Investigations ☐ List of medication ☐Other

Any other comments:

Date (dd/mm/yyyy): Person completing form: