

MCH Specialist Palliative Care Referral Form

Wisdom Hospice, High Bank, Rochester KENT ME1 2NU

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NOTE: Incomplete forms will take up to 5 working days to process

DO NOT refer patients who have not consented to referral

Surname:	Male/Female:
First Name:	Date of Birth:
Address:	
Post Code:	Ethnicity:
Telephone:	
Mobile Telephone:	NHS No:

Patient lives alone? Yes No Patient has consented to referral? Yes No
 Able to attend outpatient clinic appointment Needs home visit as housebound

Primary diagnosis(es) and key treatments: DNACPR completed

Please DO NOT refer patients undergoing curative treatment

Person completing this form:

Name:	Designation:	Contact No:
Address:		
email address for correspondence:		
Date:		

<p>Next of Kin/Main Carer</p> <p>Name:</p> <p>Tel No:</p> <p>Mobile:</p> <p>Relationship:</p> <p>Key Code to access house (if applicable):</p>	<p>General Practitioner</p> <p>Name:</p> <p>Address:</p> <p>Postcode:</p> <p>Tel No:</p> <p>Email:</p>
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Correspondence and MedicationPlease attach: Recent hospital letters Medication list/TTO's

Allergies:

Special Considerations

First language, if not English:

Communication in English: Good/Fair/Poor

Would an interpreter be helpful: Yes No

Pressure Area Status:

Other consideration: Disability/Bariatric Care

Infection status:**Reason(s) for referral** tick if referral is urgent (contact within 2 days) tick for referral to Wellbeing and Therapy Centre only tick for referral to support Advance Care Planning only**What have been the patient's main problems or concerns over the past 3 days?**

1.

2.

3.

Below is a list of symptoms, which they may or may not have experienced. For each symptom, please tick one box that best describes how it has affected them over the past 3 days.

	Not at all	Slightly	Moderately	Severely	Over-whelmingly
Pain	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other physical symptom(s)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	Not at all	Occasion-ally	Sometimes	Most of the time	Always
Has the patient been feeling anxious or depressed?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Has any of their family or friends been anxious about them?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Does the patient have any practical problems resulting from their illness?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>