



**REFERRAL TO CALDERDALE SPECIALIST PALLIATIVE CARE SERVICE**

**Patient details: (print clearly – no labels)**

CRH Hospital No: ..... NHS No: .....

Surname: ..... First name: ..... Title: ..... DOB: .....

Address: ..... Age: ..... Sex: M / F

.....

..... Post code: ..... Tel No: .....

Current location: ..... Tel No: .....

Lives alone: YES/NO Religion: ..... Ethnicity: ..... Occupation: .....

Name/relationship of carer: .....

**DOES THE PATIENT REQUIRE OXYGEN? YES/NO**

**Next of kin / carer details:**

Full name: ..... Relationship: ..... Tel No: .....

Address: .....

..... Post code: .....

NOK contact (if different): .....

**Disease status:**

Diagnosis: ..... Date of diagnosis: .....

Spread/complications: .....

Disease stage: **early/advanced** Disease management: **curative/non-curative**

Past/current treatments: .....

Patient's understanding of diagnosis: .....

Carers understanding of diagnosis: .....

Is patient aware of referral:  Yes  No

**Professionals involved:**

Consultant(s): ..... GP:..... D/N:.....

..... Tel: ..... Tel: .....

..... Address: ..... Address: .....

.....

Other (including clinical nurse specialists).....

**Patient name:**

**DOB:**

**Specialist palliative care needs**

Please state as fully as possible the main problems that have led to the request for specialist palliative care assessment. Include relevant information on physical symptoms (including mobility), carers needs, psycho-social/spiritual issues and difficult ethical needs as appropriate

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**Where do you feel these needs could be best met? (Indicate one or more options)**

Please send completed forms to appropriate location or, if you think this is urgent, please telephone the relevant team and fax the completed form as indicated below:-

- Patient assessment home/hospital
- Outpatient appointment

- Inpatient palliative care unit/Hospice
- Specialist Palliative Day Hospice
- Complementary Therapy (Thursdays only)
- Planned Respite Care

Specialist Palliative Care Team  
Macmillan Unit, Calderdale Royal  
Hospital  
HALIFAX HX3 0PW  
Tel: 01422 222700 Fax: 01422 222701

Overgate Hospice  
30 Hullen Edge Road, ELLAND HX5 0QY  
Tel: 01422 379151 Fax: 01422 375507

Referring person

Name: (please print) ..... Designation: .....

Signature: ..... Date: .....

Contact no: ..... Ward.....

(Signature confirms approval of patient's GP or Consultant)

'For office use only' Priority : Routine / Urgent

Date received:..... First contact : ..... Assessed: .....Outcome:

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