St. Anne's Hospice
Harding Avenue, Newport, S. Wales. NP19 6ZE
Tel. 01633 820317 Fax. 01633 820387

REFERRAL FORM

Please discuss all urgent referrals with the doctors on duty at St Anne's.

Hospice Use Only
Date placed on list..
URGENCY: L M H U
Estimated date of admission given....................................
Contingency plan..
Date off list/reason...

Date:
PATIENT NAME:
D.O.B:
Address:

Patient's current location:
Patient contact telephone number:

Referrer name/agency:
Referrer contact number:

GP Name and Practice:

GP telephone number:
GP fax number:

District nurse involved:
Consultants involved:

Who made the last clinical assessment and when?

DIAGNOSIS: (please give details of primary and secondary sites)

Purpose of referral: **Anticipated Terminal Care** ☐ **Symptom Control** ☐ **Procedure/Treatment** ☐ **Respite** ☐

Urgency of need for admission: **Immediately** ☐ **Within 48 hrs** ☐ **Within 2-5 days** ☐ **Within 1-2 weeks** ☐

CURRENT PROBLEMS

(please include details of strategies already employed to improve situation, continuing overleaf if necessary):

Has permission for referral been obtained from the patient/family? **Y** ☐ **N** ☐ Has continuing care funding been applied for? **Y** ☐ **N** ☐

(This section must be completed. Please circle a value from the categories below, using your patient's own evaluation whenever possible, based on an overall estimate of the past 24 hours.)

Pain	None	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Tiredness/fatigue	None	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Nausea	None	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Short of breath	None	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Constipation	None	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Depression	Not at all	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Feeling anxious	Not at all	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Drowsiness	Not at all	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Appetite	Normal	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Wellbeing	Normal	0___1___2___3___4___5___6___7___8___9___10	Worst possible
Other symptoms (please state below):			
....		0___1___2___3___4___5___6___7___8___9___10	Worst possible
....		0___1___2___3___4___5___6___7___8___9___10	Worst possible

This symptom evaluation has been made by: (please circle) **Patient** **Carer** **Professional**

(This section is an evaluation made by the healthcare professional making this referral. Please circle the most appropriate description from the categories below and give details overleaf.)

Family anxiety	None	Occasional	Sometimes	Most of the time	Overwhelming
Spiritual distress	Content	Minimal	Sometimes	Troubled	Distraught
Care environment	Appropriate	Mildly unsuitable	Moderately unsuitable	Mostly unsuitable	Totally unsuitable

Please add any further important details below:

OUTCOMES (For Administration Purposes only):

Date of referral	**Date:**				
Has the referral form been seen by a Palliative Care Doctor	**Yes**	**No**	**Date:**	**Number of Days on waiting list**	
Is the referral form complete?	**Yes**		**No**	**Bed declined by patient**	
Further information requested	**Date:**			**Bed declined by referrer**	
Has relevant information been obtained	**Yes**		**No**	**Delayed admission**	***Reason:***
Information obtained from Canisc	**Yes**		**No**	**Died before admission**	
Admission	**Date:**			***Comments:***	
Referrer informed	**Yes**	**No**	**Date:**		

***KEY** (*if appropriate*)

Patient Choice	**1**	**Unavailable Bed**	**3**	**Logistical Delays**	**5**	**Staff Shortage**	**7**
Family Decision	**2**	**Admitted Elsewhere**	**4**	**Infection Control Issues**	**6**	**Medical Staffing**	**8**