HOSBIS DEWI SANT ST DAVID'S HOSPICE
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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

St. Kentigern HOSPICE & PALLIATIVE CARE CENTRE HOSBIS A CHANOLFAN GOFAL
Tel: 01745 585221
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Specialist Palliative Care Team, BCUHB Central
Tel No: 01745 448720 ext 7690 Fax: 01745 445947

Referral Form

Date referral made: _____

NHS no:	Hospital no:
Patient name:	
Patient's Address:	
	Post Code:
Telephone no:	
DOB: / /	Gender: ☐ M ☐ F
Marital status:	Lives alone? ☐ Y ☐ N
Current location of patient:	
Preferred language:	
Next of kin name:	
Telephone no:	
Main carer name:	
Telephone no:	

Referral to:
- ☐ Nursing
- ☐ Medical
- ☐ Occupational Therapy
- ☐ Social Work input
- ☐ Hospice services: Daycare
- ☐ Hospice services: Inpatient care
- ☐ Hospice services: respite

Hospital consultant(s):
GP name:
GP address:
Practice telephone no:

Diagnosis: Please state:

☐ new diagnosis ☐ recurrence ☐ advanced disease ☐ terminal care

Relevant recent treatment/medication:

Relevant comorbidities:

Is the patient aware of the diagnosis? ☐ Y ☐ N	Is the patient aware of this referral? ☐ Y ☐ N
Is the main carer aware of the diagnosis? ☐ Y ☐ N	Is the main carer aware of this referral? ☐ Y ☐ N

Any identified risk?

Reason for referral:

Please select ☒ the appropriate box(es) **and** then use the free text area to specify **Specialist Palliative Care needs**. For more details and guidance, see Referral Criteria

- ☐ Pain & Symptom Management
- ☐ Psycho-social support for patient and/or family
- ☐ Care of the dying patient and their family
- ☐ Functional/ADL Assessment

Priority of referral:
- ☐ Urgent (to be assessed within 2 days)
- ☐ To be assessed within 10 days

Main Problems:

If the referral is for Hospice inpatient care, please answer the following additional questions:

Is the patient MRSA+? ☐ Y ☐ N ..... C diff +? ☐ Y ☐ N

Has resuscitation issues been discussed with the patient and/or family? ☐ Y ☐ N ☐ Don't know

The patient's resuscitation status is: ☐ for CPR ☐ not for CPR

Referrer details

Signature:	Name(printed capitals):
Contact number:	Designation:

For OFFICE USE ONLY:	Date/Time ref received:
☐ New referral/ ☐ Re-referral	Date contacted: