St David's Hospice • Hosbis Dewi Sant
Abbey Road/Ffordd yr Abaty, Llandudno, Conwy LL30 2EN
Tel/Ffôn: 01492 879058 **Fax/Ffacs:** 01492 870564
www.stdavidshospice.org.uk

REFERRAL FORM FOR SPECIALIST HOSPICE PALLIATIVE AND SUPPORTIVE CARE

Please Fax to 01492 870564
All referrals received are triaged within 24 hours

ELIGIBILITY CRITERIA

Essential:

- The patient has a medical condition which is significantly life limiting.
- The patient can be referred at diagnosis if the prognosis is poor.
- The referral has been discussed by the referrer with the patient who agrees to the referral. (Where the patient lacks capacity a referral must be completed as a Best Interests Decision in accordance with the Mental Capacity Act).

Plus one or more of the following:

- The patient has complex symptom management problems.
- The patient and/or their families have psychosocial, emotional or spiritual needs.

Referral to Inpatients: Urgent ☐ Non-Urgent ☐		**Referral to Day Therapy: Urgent ☐ Non-Urgent ☐**	
Patient's Name & Address: **Post code:**	**Date of Birth:**	**Tel Number:**	
	Gender:	**Ethnicity:**	**Preferred Language:**
NHS Number:	**Hospital Number:**	**Current location of patient:**	
Diagnosis: **Other medical conditions:**	**Is patient aware of:** **Diagnosis: Yes ☐ No ☐** **Prognosis: Yes ☐ No ☐** **Has patient consented to this referral:** **Yes ☐ No ☐**		
SPECIFIC REASONS FOR REFERRAL - please be clear about the issues that require our involvement.			
PATIENT'S GP AND SURGERY TELEPHONE NUMBER:	**GP aware of referral** **Yes ☐ No ☐**		

Name of main carer or significant other: **Relationship to patient:** **Is it appropriate to discuss referral with this person?** **Yes** ☐ **No** ☐	**Address** (if different to the patient) **Contact number:**
REFERRED BY: Name & Designation **Contact number:**	**Signature:** **Date:**

OTHER PROFESSIONALS INVOLVED (name & phone number desirable)		
Hospital Consultant/s		
District Nurses/Community Matron		
Specialist Nurse		
Continuing Healthcare Caseworker		
Social Services		
Other (name & role)		
Key Worker		
Continuing Healthcare Funding applied for?	**Yes** ☐ **No** ☐	**Date:**
Continuing Healthcare Funding agreed?	**Yes** ☐ **No** ☐	**Date:**

Is the patient on the Palliative Care Register? **Yes** ☐ **No** ☐ **If yes, what colour coding?**	**Is the patient registered on CaNISC?** **Yes** ☐ **No** ☐ **Please include DNACPR and brief patient summary & medication list**
Please give details of any risk factors to be aware of when caring for this patient:	

ESSENTIAL SUPPORTING DOCUMENTATION REQUIRED FOR PATIENTS NOT REGISTERED ON CANISC

- **Brief patient summary & medication list**
- **Recent & relevant consultation letters**
- **MDT reports**
- **Scan reports**
- **Advance care plan and/or DNACPR form**
- **Comprehensive details of diagnosis**
- **Treatment to date**
- **Discharge summary**
- **Future plans**
- **For community patient - blister packs/repeat prescriptions**
- **For BCUHB transfer medical notes to accompany patient**

TO AVOID UNNECESSARY DELAY PLEASE ENSURE FORM IS FULLY COMPLETED AND ALL SUPPORTING DOCUMENTATION PROVIDED