

North West London Specialist Palliative Care Referral Form

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|--|--|--|--|
| Charing Cross Hospital <input type="checkbox"/> Tel:020 8846 1412 Fax: 020 8383 0612 | Harefield Hospital <input type="checkbox"/> Tel:01895 828989 Fax: 01895 828989 | West Middlesex Hospital <input type="checkbox"/> Tel:020 8321 5787 Fax: 020 8321 5249 | Michael Sobel House <input type="checkbox"/> Tel:01923 844302 Fax: 01923 844565 |
| Chelsea and Westminster FT <input type="checkbox"/> Tel: 020 8746 8499/8268 Fax:020 8746 8863 | Hillingdon Hospital <input type="checkbox"/> Tel:01895 279412 Fax 01895 279452 | Harlington Hospice <input type="checkbox"/> Tel: 020 8759 0453 Fax: 020 8759 0600 | Pembridge Palliative Care Centre <input type="checkbox"/> Tel: 020 8962 4406 Fax: 020 8962 4407 |
| Central Middlesex Hospital <input type="checkbox"/> Tel:020 8453 2699 Fax: 020 8453 2678 | Northwick Park Hospital <input type="checkbox"/> Tel:020 8869 2546 Fax: 020 8869 2693 | Harrow Community Team <input type="checkbox"/> Tel: 020 8382 8084 Fax: 020 8382 8085 | St John's Hospice <input type="checkbox"/> Tel:020 7806 4040 Fax: 020 7806 4041 |
| Ealing Hospital <input type="checkbox"/> Tel: 020 8967 5000 -3086/3089 Fax 020 8967 5073 | Royal Brompton Hospital <input type="checkbox"/> Tel:020 7351 8511 Fax: 020 7349 7738 | Hillingdon Community Team <input type="checkbox"/> Tel:01895 279412 Fax: 01895 279452 | St Luke's Hospice <input type="checkbox"/> Tel:020 8382 8000 Fax:020 8382 8080 |
| Hammersmith Hospital <input type="checkbox"/> Tel:020 8383 1531 Fax; 020 8383 3345 | St Mary's Hospital <input type="checkbox"/> Tel: 020 7886 6011 Fax: 020 7886 1440 | Meadow House Hospice <input type="checkbox"/> Tel: 020 8967 5178 Fax 020 8967 5756 | Trinity Hospice <input type="checkbox"/> Tel: 020 7787 1000 Fax: 020 7787 1067 |

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

| Essential Patient Details | | | |
|---------------------------|-----------------------|---|--|
| Surname | Age: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Key worker: |
| First Name | DoB | | Is GP aware of referral Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Address | Marital Status | | Patient consent to palliative care involvement Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Post Code | Ethnicity | | Office Use |
| Tel | Mobile Tel | | |
| NHS number: | Hospital No: | PCT number: | |

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| Primary diagnosis(es) |
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| Communication | Other barriers to communication: |
| Fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No (If 'no' proceed with remaining questions) | |
| First Language if not English: | |
| Would interpreter be helpful to patient and Palliative Care staff? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

| Next of Kin/Patient Representatives | Name | Address |
|-------------------------------------|--------------------------------|---------|
| Telephone | Relationship to patient | |

| | | |
|--|-------------|-----------------|
| District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/> | Name | Based at |
| Telephone | Fax | |

| | | |
|-----------------------------|-------------|----------------|
| General Practitioner | Name | Address |
| Telephone | Fax | |

| | | |
|---|-------------|------------------|
| Main Carer (if different from above) | Name | Telephone |
|---|-------------|------------------|

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|---|------------------|--|
| Social Services Yes <input type="checkbox"/> No <input type="checkbox"/> | Name | Based at |
| Telephone | Fax/email | Continuing care assessment completed: |

| Reason for Referral | Service requested | The patient is currently |
|--|---|--|
| Pain/symptom control <input type="checkbox"/> Emotional/psychological support <input type="checkbox"/> Social/financial <input type="checkbox"/> Assessment for hospice admission <input type="checkbox"/> Carer support <input type="checkbox"/> Other reason e.g. (spiritual, lymphoedema) <input type="checkbox"/> | Home assessment and support <input type="checkbox"/> Hospital assessment <input type="checkbox"/> Day Care <input type="checkbox"/> Admission (circle) <input type="checkbox"/> respite /symptom control / terminal care <input type="checkbox"/> Hospice at home (contact service directly for referral details) <input type="checkbox"/> | At Home <input type="checkbox"/> In Hospital (see over) <input type="checkbox"/> Other e.g. Nursing Home <input type="checkbox"/> Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| Hospital | Telephone |
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| IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/> <b style="color: blue;">IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE |
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Referrer name: _____ Signature: _____ contact number: _____

