SPECIALIST PALLIATIVE CARE SERVICES

IN BRADFORD AND AIREDALE

COMMON REFERRAL FORM

All the specialist palliative care services in Bradford Health District offer multiprofessional care to people with any progressive, incurable illness – not just those with cancer.

Use this form to make a referral to any of the services listed below. Please complete it accurately in black ink and send it to the appropriate service.

This will help us to provide prompt, effective care.

Please note:

1. Home assessment/support is provided by the Community Palliative Care Team in the city of Bradford, by Manorlands in Airedale and by the Marie Curie Community Specialist Nurse in Ilkley.

2. The hospices also offer inpatient admission (for symptom control, respite, rehabilitation or terminal care); daycare; and medical outpatient assessment.

3. The services expect a patient's GP and District Nurse to be informed that a referral has been made. For hospital inpatients, the responsible Consultant should also be aware of the referral.

WHICH SERVICE ARE YOU REFERRING THE PATIENT TO? (PLEASE TICK)

☐ **Bradford Community Palliative Care Team**
Marie Curie Hospice, Maudsley Street, Bradford BD3 9LE
Tel 01274 323511 **Fax 01274 323509**
E-mail: christine.stubbs@bradford.nhs.uk
Website: www.palliativecare.bradford.nhs.uk

☐ **Manorlands Specialist Palliative Care Home**
Hebden Rd, Oxenhope BD22 9HJ
Tel 01535 642308 **Fax 01535 642902**
E-mail: joanna.longden@bradford.nhs.uk

☐ **Marie Curie Hospice, Bradford**
Maudsley St Bradford BD3 9LE
Tel 01274 337000 **Fax 01274 337094**
E-mail: louise.keighley@mariecurie.org.uk

☐ **Marie Curie Community Specialist Nurse**
Springs Medical Centre, Springs Lane, Ilkley LS29 8TH
Tel 01943 817957 **Fax 01943 817957**
E-mail: janet.munro@mariecurie.org.uk

NCPC GOOD PRACTICE EXAMPLE

SPECIALIST PALLIATIVE CARE REFERRAL FORM

PATIENT DETAILS

Surname: Williams **First name Brian** **DOB; 7/7/34**

Tel:…………………………… **NHS No.** ………..…………… **Hospital No.** ……………………

Home address………………………………………………………………… **Post Code**…………….………..

Where is the patient at present? ………………………………………………………………

First language (if not English): ……………………... *Is an interpreter necessary?* Yes ☐ No ☐

Religion: ……………………………………….. ***S**ex*: Male ☐ Female ☐ Lives Alone Yes ☐ No ☐

Ethnicity ……………………………………….. *Occupation/Status*……… ……………………………………

WHAT IS THE REFERRAL FOR?

Home assessment / support ☐ **Medical outpatient assessment** ☐

Hospice admission ☐ **Day hospice** ☐ **Lymphoedema clinic** ☐ **Psychological Needs** ☐

*Is this referral **urgent**? (i.e. service needed within 2 working days)* **Urgent** ☐ **Non urgent** ☐

*Please confirm that **the patient is aware of the referral**:* **Yes** ☐ **No** ☐

DETAILS OF MAIN CARER

Name:……………………………………… **Address**:………………………………..………………………

Tel: ………………………………… **Relationship to patient:** …………………………………….……..

Details of next of kin (if different from above): …………………………………………………..………………..

Please list all those living at same address as patient: ………………………………………..…………………

PROFESSIONALS INVOLVED	Name	Address	Tel. No.
General Practitioner:	....	....	....
Consultants:	....	....	....
	....	....	....
District Nurse:	....	....	....
Palliative Care Team:	....	....	....
Social Worker:	....	....	....
Others:	....	....	....
	....	....	....

NCPC GOOD PRACTICE EXAMPLE

PATIENT'S NAME:

DISEASE STATUS

Diagnosis: …………………………………………………….……. **Date of diagnosis:** …………….……..…..

Sites of metastases: *(if malignancy)*………………………………….……………………………………..

Past/current disease management: (*send copies of discharge summaries, correspondence etc)*……….….……..….

………..…

……………………………………………………………..…………………………………………………..…..

Relevant past medical history: ………………………………………………………………………….…….…

Current medication: *(including doses)*

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Allergies / adverse drug reactions: ……………………………………………………………………..……

What has the patient been told about their illness?

………..…….

What have the family/carers been told about the illness?

………..…….

CURRENT PROBLEMS

What are the problems you want the palliative care service to help with?

Please give details of:
Uncontrolled symptoms or physical problems

Psychosocial issues

Needs of carers or other family members

Additional relevant information:
Continue overleaf or attach letters etc as appropriate

REFERRING PERSON

Name: *(please print)* ………………………… **Designation:** ………………………… **Date:** ……….…..

Address: …………………………………… **Tel:**……………………… **Signature:** ………………………..

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