

# West London Specialist Palliative Care Referral Form

<b>Charing Cross Hospital</b> <input type="checkbox"/> Tel:020 8846 1412 Fax: 020 8383 0612	<b>Harefield Hospital</b> <input type="checkbox"/> Tel:01895 828989 Fax: 01895 828989	<b>West Middlesex Hospital</b> <input type="checkbox"/> Tel:020 8321 5787 Fax: 020 8321 5249	<b>Michael Sobel House</b> <input type="checkbox"/> Tel:01923 844302 Fax: 01923 844565
<b>Chelsea and Westminster FT</b> <input type="checkbox"/> Tel: 020 8746 8499/8268 Fax:020 8746 8863	<b>Hillingdon Hospital</b> <input type="checkbox"/> Tel:01895 279412 Fax 01895 279452	<b>Harlington Hospice</b> <input type="checkbox"/> Tel: 020 8759 0453 Fax: 020 8759 0600	<b>Pembridge Palliative Care Centre</b> <input type="checkbox"/> Tel: 020 8962 4406 Fax: 020 8962 4407
<b>Central Middlesex Hospital</b> <input type="checkbox"/> Tel:020 8453 2699 Fax: 020 8453 2678	<b>Northwick Park Hospital</b> <input type="checkbox"/> Tel:020 8869 2546 Fax: 020 8869 2693	<b>Harrow Community Team</b> <input type="checkbox"/> Tel: 020 8382 8084 Fax: 020 8382 8085	<b>St John's Hospice</b> <input type="checkbox"/> Tel:020 7806 4040 Fax: 020 7806 4041
<b>Ealing Hospital</b> <input type="checkbox"/> Tel: 020 8967 5000 -3086/3089 Fax 020 8967 5073	<b>Royal Brompton Hospital</b> <input type="checkbox"/> Tel:020 7351 8511 Fax: 020 7349 7738	<b>Hillingdon Community Team</b> <input type="checkbox"/> Tel:01895 279412 Fax: 01895 279452	<b>St Luke's Hospice</b> <input type="checkbox"/> Tel:020 8382 8000 Fax:020 8382 8080
<b>Hammersmith Hospital</b> <input type="checkbox"/> Tel:020 8383 1531 Fax; 020 8383 3345	<b>St Mary's Hospital</b> <input type="checkbox"/> Tel: 020 7886 6011 Fax: 020 7886 1440	<b>Meadow House Hospice</b> <input type="checkbox"/> Tel: 020 8967 5178 Fax 020 8967 5756	<b>Trinity Hospice</b> <input type="checkbox"/> Tel: 020 7787 1000 Fax: 020 7498 9726

**PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM**

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

<b>Primary diagnosis(es)</b>
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<b>Communication</b>	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"/>

<b>Next of Kin/Patient Representatives</b>	<b>Name</b>	<b>Address</b>
<b>Telephone</b>	<b>Relationship to patient</b>	

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

<b>General Practitioner</b>	<b>Name</b>	<b>Address</b>
<b>Telephone</b>	<b>Fax</b>	

<b>Main Carer</b> (if different from above)	<b>Name</b>	<b>Telephone</b>
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<b>Social Services</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Name</b>	<b>Based at</b>
<b>Telephone</b>	<b>Fax/email</b>	
<b>Continuing care assessment completed:</b>		

<b>Reason for Referral</b>	<b>Service requested</b>	<b>The patient is currently</b>
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"/>

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</b>
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Referrer name:

Signature:

contact number:

