

SPECIALIST PALLIATIVE CARE SERVICES

IN BRADFORD, AIREDALE, WHARFEDALE & CRAVEN

COMMON REFERRAL FORM

Specialist palliative care services across the Bradford, Airedale and Craven district offer multi-professional care to people with any advanced, progressive, incurable illness – not just those with cancer.

Use this form to make a referral to any of the services listed below. Please complete in full with 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 Bradford area, by Sue Ryder Manorlands in the Airedale/Craven/Wharfedale area.
2. Both hospices also offer inpatient care (for symptom control, rehabilitation or terminal care) day therapy and medical outpatient assessment.
3. The service expects the patient, their 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

Based at Shipley Health Centre,
Alexandra Road, Shipley BD18 3EG

Tel 01274 221151

Email: Fax-HPK.Admin-Hub@bdct.nhs.uk

Sue Ryder Manorlands Hospice

Hebden Rd, Oxenhope BD22 9HJ

Tel 01535 642308

Email: admin.manorlands@nhs.net

Marie Curie Hospice, Bradford

Maudsley St Bradford BD3 9LE

Tel 01274 337000

Email: mariecuriebradford@nhs.net

SPECIALIST PALLIATIVE CARE REFERRAL FORM

PATIENT DETAILS

Surname..... First name(s)..... DOB.....

Tel..... NHS No.

Home address..... Post Code.....

Where is the patient at present?

First language (if not English): Is an interpreter necessary? Yes No

Sex: Male Female Lives Alone Yes No

PLEASE ASK THE PATIENT FOR CONSENT TO SHARE THEIR GP RECORD WITH THE PALLIATIVE CARE SERVICE

Shared care granted: Yes No

WHAT IS THE REFERRAL FOR?

Home assessment / support Medical outpatient assessment

Hospice admission Day therapy Psychological needs

How quickly does this patient need to be seen?

Within 2 working days Give reason: Severe physical symptoms Severe psychological distress

3-5 working days

1-2 weeks

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):

PROFESSIONALS INVOLVED

Name

General Practitioner:

District Nurse:

Others e.g Specialist Nurses, Social Worker or Community Matron

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

On GP Gold Standards Framework? Yes No Don't know

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**