# 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)**

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**Bradford Community Palliative Care Team**
Based at Shipley Health Centre,
Alexandra Road, Shipley BD18 3EG ☐

Tel 01274 221151 **Fax 01274 215660**

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**Sue Ryder Manorlands Hospice**
Hebden Rd, Oxenhope BD22 9HJ ☐

Tel 01535 642308 **Fax 01535 644605**

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**Marie Curie Hospice, Bradford**
Maudsley St Bradford BD3 9LE ☐

Tel 01274 337000 **Fax 01274 337095**

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# 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 ……**