Rochdale Old Road, Bury, BL9 7RG Tel: 0161 725 9800

REFERRAL FORM

Please ensure that you complete the form in **full** as this helps us to prioritise our referrals. **Incomplete referrals will be returned for completion and could lead to a delay in the patient accessing our services.**
If you wish to speak to the team before referral or if the referral is **urgent please contact the Hospice directly**.
Please note. Inpatient referrals are triaged daily at 8am and admissions usually take place before 1pm.

Inpatient Unit ☐	Outreach Team ☐	Complementary Therapy ☐	Medical Outpatients ☐

Patient Information	Has the patient consented to referral? Y/N			
Name	Marital Status			
Address	D.O.B.			
	NHS No:			
Post Code	Does the patient live alone:			
Telephone No:	Ethnicity:		Religion :	

Next of Kin Details	G.P Practice
Name:	GP:
Relationship to Patient:	Surgery Address:
Address:	
Post Code	Post Code:
Tel No:	Tel No:

Primary Diagnosis:	Hospital Consultant:
Date of diagnosis:	Name:
Site (s) of metastases:	Hospital
Other significant diagnosis:	Specialist Nurse
	Other healthcare prof involved:

Relevant Medical History:	Current Drug History:	
	Allergies:	

Location of Patient:			
☐ Home		☐ Other (please specify)	
☐ Hospital (please provide telephone number)			
Does the patient have a uDNACPR?	Yes ☐	No ☐	

Has the patient any known infectious diseases? E.g. MRSA, C Diff, Hepatitis etc.	Yes ☐	No ☐
Does the patient have a DoLS in place?	Yes ☐	No ☐
Are the patient and family aware of current situation?	Yes ☐	No ☐

Please send completed referrals for the inpatient unit to bhosp.inpatientreferrals@nhs.net

Inpatient Unit	**Reason for referral: ☐ Symptom Management ☐ End of Life Care**
Estimated Prognosis Days ☐ Weeks ☐ Months ☐	
The hospice is a short stay unit. Has this been discussed with patient and family? Yes ☐ No ☐	
Aims of admission, why would the patient benefit from the service:	
.	
If the patient is in hospital are the following available TTO ☐ Discharge Summary ☐ (Required for admission)	

Please send completed referrals for the Outreach team to bhosp.outreachreferrals@nhs.net

Outreach Team	**Reason for referral ☐ Nursing/Education ☐ Social/Respite**

Details of current situation and aim of outreach team:
Who provides current care and support:
Any identified risks for a lone worker (if so please state)
Is there a Key safe? Please state number

Please send completed referrals for Complementary Therapy and Medical Outpatients to bhosp.supportivecarereferrals@nhs.net

Complementary Therapy	**Reason for referral:**

Details of current situation and how complementary therapies may help:

Medical Outpatients	**Reason for referral ☐ Symptom Management ☐ Other ☐**

Details of current situation and aim of medial outpatient appointment:
Please attach a transfer of care document and any relevant clinic letters to support the assessment.

Referrer Details	**Name:**	**Designation:**
Date of Referral:	**Phone No:**	**Fax/Email:**