ALL WALES PALLATIVE CARE SERVICES REFERRAL FORM

(all urgent referrals should be discussed verbally)

Surname	D.O.B.	Referrer	Designation	Date Referred
First Names	Title	Agency	Contact Number	

male ☐ female ☐ **Consultant(s)** 1. 2.

NHS No: Case Record No: **Next of Kin**

Address

Relationship to Patient

Address (if different from patient)

Post Code

Contact Number

Contact Number

Main Carer (if different from above)

Current Location

Contact Number

G.P.

Practice Address

Patient Demographics

Single ☐ Married ☐ Civil Partnership ☐ Separated ☐

Divorced ☐ Widowed ☐ Co Habiting ☐

Post Code

G.P. Tel No. Fax No.

Ethnic Group (collected for equality and diversity monitoring - require patient consent):

Any white Background ☐	Mixed white and black African ☐	Mixed white and Asian ☐	Other mixed background ☐
Mixed white and black Caribbean ☐	Pakistani / British Pakistani ☐	Bangladeshi / British Bangladeshi ☐	Indian / British Indian ☐
Black African / black British African ☐	Black Caribbean / black British Carribean ☐	Other Asian (not chinese) ☐	Chinese ☐
Any other ethnic group ☐	Other Black Background ☐		

Is District Nurse in attendance Yes ☐ No ☐

Community SPC Nurse Name/Agency

Diagnosis

Secondary Metastatic Sites (if relevant)

Preferred Spoken Language

Religion / Belief System

Previous Treatments:

Any other relevant information? (e.g. current or planned treatment)

Co-existing medical conditions / Past medical history

Present Medication

Allergies

Adverse Reactions

MRSA positive Yes ☐ No ☐ Clostridium Difficile Positive Yes ☐ No ☐ Other transmittable Infections? Yes ☐ No ☐

Palliative Care Services - Referral Form Part 2

Patient Name

Describe patient's (and relatives') understanding of disease & prognosis

Social situation

Who is aware of referral? Patient ☐ Carer ☐ Consultant ☐ G.P. ☐

Which Service is Required? (Not all available from all providers)

Hospital Review / Assessment	☐			Specialist Community Palliative Care Nurse			☐
Out Patient Appointment	☐	Day Care	☐	Domicilliary Visit	☐	Dietician	☐
In Patient Bed	☐	Social Worker	☐	O.T.	☐	Physio	☐

Urgency:- Immediately ☐ Within 48 Hours ☐ Within 2 - 5 Days ☐ Within 1 - 2 Weeks ☐

Reason for Referral

Symptom Control	☐	Procedure/Treatment (specify.....)		☐	
Discharge Planning	☐	Rehabilitation	☐	Respite	☐
Info/Advice	☐	End of Life Care	☐	Other.....	
Psychological Support for Carer	☐	Psychological Support for Patient	☐		

Symptom Evaluation

Please circle the severity of the following from 0 - 10 0 being absent and 10 being overwhelming

Pain	0 1 2 3 4 5 6 7 8 9 10	Patient Emotional dist	0 1 2 3 4 5 6 7 8 9 10
Agitation	0 1 2 3 4 5 6 7 8 9 10	Family distress	0 1 2 3 4 5 6 7 8 9 10
Nausea	0 1 2 3 4 5 6 7 8 9 10	Other (specify):	0 1 2 3 4 5 6 7 8 9 10
Dyspnoea	0 1 2 3 4 5 6 7 8 9 10		0 1 2 3 4 5 6 7 8 9 10

Has this patient made any advance decisions e.g. resuscitation

Current Problems

Additional Information

Referral Received by: Planned Action: