|  |  |  |
| --- | --- | --- |
|  |  **Referral Form: Specialist Palliative**  **Care Services** **FOR H@H REFERALS PLEASE PHONE : 01904 777 770**  |  |

**St Leonards Hospice** **Inpatient Unit**  [ ]  **Community Palliative Care Team**  [ ]

(Referral Criteria: [click here](https://stleonardshospice.org.uk/wp-content/uploads/2023/03/SLH-IPU-referral-criteria-final.pdf))

 **Urgent [ ]  Non Urgent [ ]  Date of referral:**

|  |
| --- |
| Patient name: NHS NUM: |
| Address: DoB:  Phone no:  |
| NOK: Relationship: Contact details:  |
| **Consent agreed for referral?** **Y [ ]  N** [ ]  **Please note that referrals will not be accepted unless the patient or main carer has consented to the referral** |
| **DIAGNOSIS :** **Is Patient aware of diagnosis: Y [ ]  N** [ ]  **Is Patient aware of prognosis: Y [ ]  N** [ ]  Current/Planned Treatments:       |
| **MAIN CONCERNS - REASON FOR REFERRAL**Pain Symptom control Last days of life careSocial/financial Psychological pt Psychological familyACP Discussion Please outline the main Physical/Psychological/Social/ Spiritual Issues:  |
| DNACPR in place? Yes / No Anticipatory Drugs in place Yes / No |
| Name of referrer: Date of referral:  |
| Position: Contact no:  |

 Pleaseemail completed form to: **SLEHO.spcreferrals@nhs.net**

 **FOR URGENT REFERRALS PLEASE RING 01904 777 770**