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|  | **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 care  Social/financial Psychological pt Psychological family  ACP 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**](mailto:SLEHO.spcreferrals@nhs.net)

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