

West London Specialist Palliative Care Referral Form

Charing Cross Hospital <input type="checkbox"/> Tel:020 8846 1412 Fax: 020 8383 0612 Chelsea and Westminster FT <input type="checkbox"/> Tel: 020 8746 8499/8268 Fax:020 8746 8863 Central Middlesex Hospital <input type="checkbox"/> Tel:020 8453 2699 Fax: 020 8453 2678 Ealing Hospital <input type="checkbox"/> Tel: 020 8967 5000 -3086/3089 Fax 020 8967 5073 Hammersmith Hospital <input type="checkbox"/> Tel:020 8383 1531 Fax; 020 8383 3345	Harefield Hospital <input type="checkbox"/> Tel:01895 828989 Fax: 01895 828989 Hillingdon Hospital <input type="checkbox"/> Tel:01895 279412 Fax 01895 279452 Northwick Park Hospital <input type="checkbox"/> Tel:020 8869 2546 Fax: 020 8869 2693 Royal Brompton Hospital <input type="checkbox"/> Tel:020 7351 8511 Fax: 020 7349 7738 St Mary's Hospital <input type="checkbox"/> Tel: 020 7886 6011 Fax: 020 7886 1440	West Middlesex Hospital <input type="checkbox"/> Tel:020 8321 5787 Fax: 020 8321 5249 Harlington Hospice <input type="checkbox"/> Tel: 020 8759 0453 Fax: 020 8759 0600 Harrow Community Team <input type="checkbox"/> Tel: 020 8382 8084 Fax: 020 8382 8085 Hillingdon Community Team <input type="checkbox"/> Tel:01895 279412 Fax: 01895 279452 Meadow House Hospice <input type="checkbox"/> Tel: 020 8967 5178 Fax 020 8967 5756	Michael Sobel House <input type="checkbox"/> Tel:01923 844302 Fax: 01923 844565 Pembridge Palliative Care Centre <input type="checkbox"/> Tel: 020 8962 4406 Fax: 020 8962 4407 St John's Hospice <input type="checkbox"/> Tel:020 7806 4040 Fax: 020 7806 4041 St Luke's Hospice <input type="checkbox"/> Tel:020 8382 8000 Fax:020 8382 8080 Trinity Hospice <input type="checkbox"/> Tel: 020 7787 1000 Fax: 020 7498 9726
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PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE WITH THIS FORM

Essential Patient Details			
Surname	Age:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Key worker:
First Name	DoB		Is GP aware of referral Yes <input type="checkbox"/> No <input type="checkbox"/>
Address	Marital Status		Patient consent to palliative care involvement Yes <input type="checkbox"/> No <input type="checkbox"/>
Post Code	Ethnicity		Office Use
Tel	Mobile Tel		
NHS number:	Hospital No:	PCT number:	

Primary diagnosis(es)

Communication	Other barriers to communication:
Fluent in English? <input type="checkbox"/> Yes <input type="checkbox"/> No (If 'no' proceed with remaining questions)	
First Language if not English:	
Would interpreter be helpful to patient and Palliative Care staff?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Next of Kin/Patient Representatives	Name	Address
Telephone	Relationship to patient	

District Nurse Yes <input type="checkbox"/> No <input type="checkbox"/>	Name	Based at
Telephone	Fax	

General Practitioner	Name	Address
Telephone	Fax	

Main Carer (if different from above)	Name	Telephone
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Social Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Name	Based at
Telephone	Fax/email	Continuing care assessment completed:

Reason for Referral	Service requested	The patient is currently
Pain/symptom control <input type="checkbox"/> Emotional/psychological support <input type="checkbox"/> Social/financial <input type="checkbox"/> Assessment for hospice admission <input type="checkbox"/> Carer support <input type="checkbox"/> Other reason e.g. (spiritual, lymphoedema) <input type="checkbox"/>	Home assessment and support <input type="checkbox"/> Hospital assessment <input type="checkbox"/> Day Care <input type="checkbox"/> Admission (circle) <input type="checkbox"/> respite /symptom control / terminal care <input type="checkbox"/> Hospice at home (contact service directly for referral details) <input type="checkbox"/>	At Home <input type="checkbox"/> In Hospital (see over) <input type="checkbox"/> Other e.g. Nursing Home <input type="checkbox"/> Does patient live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>

IS REFERRAL URGENT (assess within 2 working days)? Yes <input type="checkbox"/> No <input type="checkbox"/> <b style="color: blue;">IF URGENT, PLEASE PHONE US FOR IMMEDIATE ADVICE
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Referrer name:

Signature:

contact number:

