Barnsley Hospice Referral Form

Please note we cannot accept a referral if any of the following information is incomplete.

Surname:	First name(s):
Date of birth: Age:	NHS No:
Address:	Hospital No:
	Marital/civil status:
	Ethnic origin:
Postcode:	Religion:
Telephone:	Current location of patient:
Is an interpreter required? Yes ☐ No ☐ If yes, which language?	Gender Male ☐ Female ☐ Other ☐ Non-binary ☐ Prefer not to say ☐
ReSPECT in place? Yes ☐ No ☐	
Does the patient have a disability? Yes ☐ No ☐	Sexual orientation:
Is the patient a carer? Yes ☐ No ☐	Is the patient pregnant or breastfeeding? Yes ☐ No ☐
Is the patient a smoker Yes ☐ No ☐ If yes, are they aware of the hospice policy?	Is patient on O2? Yes ☐ No ☐ If yes: L/min Is consultant/GP aware of referral? Yes No

1st CONTACT Name:	**2nd CONTACT** Name:
Relationship:	Relationship:
Address: Tel no:	Address: Tel no:
GP Name:	**Name and contact details of other professionals involved**: (Clinical Nurse Specialists, Community nurses etc.)
Address: Telephone:	

TYPE OF REFERRAL Urgent ☐ Routine ☐

Barnsley Hospice: Email: bdg-tr.barnsleyhospice@nhs.net Tel no: 01226 244244

Inpatient Unit ☐ **If referring outside of office hours please phone IPU to inform of referral**
Medical Outpatient Clinic or Medical Home Visit ☐
The Orangery/Support and Wellbeing Service ☐
Counselling ☐

CONSENT/CAPACITY:

Has the person named above consented to the referral?
If the patient lacks the capacity to consent to the referral has a best interest decision been made?
Yes ☐ No (please state why) ☐……..

In consultation with a Health Care Professional (referrer). Does the patient consent to the collecting, sharing, processing and viewing of data recorded with any other organisation that may care for the patient.

Consent given ☐ Consent refused ☐

The patients consent can be changed at any time.

PATIENT Name: Date of birth: NHS No:

DIAGNOSIS & PAST MEDICAL HISTORY include dates:

Is the patient aware of their main diagnosis? Yes No

Does patient have a pacemaker? Yes No Does patient have an ICD? Yes No

Infection risks (e.g. MRSA, COVID 19, C. Diff, D+V, Other)**:**

SUMMARY OF MAIN CONCERNS:
REASON FOR REFERRAL

RISKS:

Please describe in detail any identified risks or safety concerns for example safeguarding issues, drug or alcohol use, risks to the lone worker, falls risks, current pressure areas, cognitive impairment, mental health risks.

CURRENT MEDICATION INCLUDING ALLERGIES:

PATIENT Name:	Date of birth:	NHS No:

SOCIAL HISTORY:

Is patient funded under Continuing HealthCare? ☐ Yes ☐ No

ADDITIONAL RELEVANT INFORMATION:

REFERRED BY:	Post:	Contact no:
Date of referral:	Base:	Total no pages: