****Diagram

Description automatically generated

**Barnsley Community and Hospital Specialist Palliative Care Referral Form**

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| 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? | Any identified risks? |
| DNACPR in place? Yes No |
| Has patient consented to discussion with the service?  Yes No Best interest decision | Is consultant/GP aware of referral? Yes No |
| Is this a patient’s relative? Yes No |

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| **1st CONTACT** Name: | **2nd CONTACT** Name: |
| Relationship: | Relationship: |
| Address:  Tel no: | Address:  Tel no: |

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| **GP Name**: | **Name and contact details of other professionals involved**: (Clinical Nurse Specialists, Community nurses etc.) |
| Address: |  |
| Telephone: |  |

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| **Type of referral (please tick)**  Urgent (contact within 24 hours) Routine (contact within 7 days) 7 days + |
| **Barnsley Community Specialist Palliative Care team:**  **Email:** [**RightCareBarnsleyIntegratedSPA@swyt.nhs.uk**](mailto:RightCareBarnsleyIntegratedSPA@swyt.nhs.uk) **Tel no: 01226 644575**  Community Macmillan Nurse  Community Macmillan Allied Health Professional /Social Worker (please specify): |
| **Barnsley District Hospital: email:** [**bdg-tr.palliativecare@nhs.net**](mailto:bdg-tr.palliativecare@nhs.net) **Tel no: 01226 434921**  Barnsley Hospital Specialist Palliative Care Team |
| **Reason for referral (Please tick all that apply):**  Pain Symptom control Last days of life care Psychological Social/Family  Other, please specify …………………………………………………………………………………….  ………………………………………………………………………………………………………………... |

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| **PATIENT Name: Date of birth: NHS No:** |

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| **Diagnosis & past medical history** - include dates:  Is the patient aware of their main diagnosis? Yes No |

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| **Summary of main concerns including current interventions:** |
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| **Medication history including allergies:** |
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| **Additional relevant information** |
| Is patient funded under Continuing Care? Yes No |

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| --- | --- | --- |
| **Referred by:** | Post: | Contact no: |
| Date of referral: | Base: | Total no pages: |

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**Reviewed March 2022**