Andover Community Palliative Care Service Referral Form

Please email to: cobh.communityreferrals@hhft.nhs.uk

Covering Andover PCN: Adelaide Medical Centre; Andover Health Centre;Charlton Hill Surgery; Castle Practice; Gratton Surgery; Shepherd's Spring Medical Centre; Stockbridge Surgery; St. Mary's Surgery; Two River's Medical partnership)

If you would like to discuss further, please telephone the relevant part of the service.

Andover Community Palliative Care (Mon-Fri 08:30-17:00) 01264 835250	**Andover Hospice (out of hours) 01264 835288**

PATIENT DETAILS

Surname: ..... DOB: .....
First name: ..... Known as: .....
Address: .....
NHS No: .....
Telephone No: ..... Mobile No: .....
Sex: Male / Female Lives alone: **YES / NO** Are they able to attend as an outpatient? **YES / NO**

NEXT OF KIN / MAIN CARER DETAILS (if different)

Surname: .....
First name: .....
Relationship: .....
Address: .....
.....
.....
Telephone No: ..... Mobile No: .....

GENERAL PRACTITIONER

Name Dr: .....
Surgery: .....
Telephone No: .....
GP aware of referral: **YES / NO**

CURRENT LOCATION OF PATIENT (please tick)

Home ☐ Other ☐.....

REFERRER DETAILS

Name: .....
Title: .....
Department: .....
Telephone No: .....

PREDICTED PROGNOSIS

Days ☐ **Weeks** ☐ **Months** ☐ **Years** ☐

Is patient aware of referral **YES / NO**

Is the NOK/ family aware of referral **YES / NO**

Working diagnosis:

Detailed reason for referral e.g. Symptom control/Psychological support/Ethical decision making/Advance care planning:

PLEASE TICK IDEAL RESPONSE TIME

☐ **Today (Please ring to discuss)** ☐ **24-48 hours** ☐ **In next 7 day** ☐ **Non-urgent**