St. Kentigern
HOSPICE & PALLIATIVE CARE CENTRE

St Kentigern Hospice
Upper Denbigh Road
St. Asaph
LL17 ORS
Tel: 01745 585221
Fax: 01745 585224

REFERRAL FORM – PLEASE COMPLETE BOTH SIDES

Patient Name:	
Home Address:	
	Postcode:
Telephone Number:	**Mobile Number:**
Date of Birth:	**Gender:**
NHS Number:	**Hospital Number:**

Current Location:	**Lives Alone:** Yes ☐ No ☐
Main Carer:	**Relationship:**
Carers Address:	
	Postcode:
Telephone Number:	**Mobile Number:**

Referred for:		**Urgency of Referral:**	
Outpatient	☐	Emergency * (Contact within 12 hours)	☐
Day Therapy	☐	Contact within 2 days	☐
Inpatient Admission	☐	Contact within 7 days **	☐
Inpatient Respite	☐		
Physiotherapy	☐		

** If urgent, please telephone for immediate advise | ** For Outpatient/Physiotherapy/Day Therapy*

Diagnosis:

Reason for Referral: Symptom Management ☐ End of Life Care ☐ Psycho Social ☐

Information to support referral e.g. active problems:

Expectations of admission / attendance (what has been discussed with patients' family):

Day Therapy is up to 12 weeks planned. Inpatient Unit is not long stay – 7-10 days assessment

Has the patient given consent for the referral and for their information (personal and sensitive) being shared with St Kentigern Hospice? Yes ☐ No ☐

Is the patient and family aware of:	Patient				Family / Carer			
Diagnosis	Yes	☐	No	☐	Yes	☐	No	☐
Prognosis	Yes	☐	No	☐	Yes	☐	No	☐
Referral	Yes	☐	No	☐	Yes	☐	No	☐
Has resuscitation been discussed with patient and / or family?					Yes	☐	No	☐

Patient's resuscitation status: **FOR CPR** ☐ **NOT FOR CPR** ☐ *(Please tick)*

St. Kentigern
HOSPICE & PALLIATIVE CARE CENTRE
HOSBIS A CHANOLFAN GOFAL

St Kentigern Hospice
Upper Denbigh Road
St. Asaph
LL17 ORS
Tel: 01745 585221
Fax: 01745 585224

Phases of illness *(please tick):*				
Stable:	☐			
Unstable:	☐			
Deteriorating:	☐			
Dying:	☐			
Preferred Place of Care:		Preferred Place of Death:		
Have any of the following been discussed?				
Advanced Care Planning:	Yes ☐	No ☐		
Advanced Decision to Refuse Treatment:	Yes ☐	No ☐		
Lasting Power of Attorney:	Yes ☐	No ☐		
Ceiling of Care:	Yes ☐	No ☐		
Performance Status *(please tick):*				
1. Normal activity with effort. Some signs of synptoms of disease	☐			
2. Considerable assistance and frequent medical / nursing care required	☐			
3. In bed 50% of the time	☐			
4. Total bedfast, requiring extensive nursing care by professional and / or family	☐			

Current medications and any recent changes:								
Alerts:								
Allergies	Yes	☐	No	☐	Infection	Yes	☐	No ☐
ICD's	Yes	☐	No	☐				
Pacemaker	Yes	☐	No	☐	*Please specify*			
Oxygen Therapy	Yes	☐	No	☐				
If yes how many litres:								

GP's Name:		
GP's Address:		
		Postcode:
Telephone Number:		**Fax Number:**
District Nursing: Yes ☐	No ☐	**District Nursing Team:**
Telephone Number:		**Fax Number:**
Specialist Palliative Care CNS:		
Consultant(s):		
Others (e.g. Oncology, Dietician, Care Providers / Agencies, Hospice at Home etc.):		

Any other information:	
Referral by:	*(Please print)*
Telephone Number:	**Date:**
Signed:	