St Clare Hospice

Hand in hand we care

St Clare Hospice Referral Form

Please email to SCLHO.referrals@nhs.net
or fax to 01279 773 771
24hr Advice Line 01279 773 773

St Clare Hospice
Hastingwood Road
Hastingwood
Essex CM17 9JX
stclarehospice.org.uk

Direct Dial Telephone Numbers

Inpatient Unit	**01279 773 779**
Community Palliative Care Team	**01279 773 711**
Hospice at Home	**01279 773 716**
Day Therapy	**01279 773 768**

PATIENT DETAILS *(In capitals please)*

Surname ..... First name .....

Address .....

.....

Postcode ..... Tel .....

DOB ..... Gender ..... NHS number .....

PRIMARY DIAGNOSIS .....

.....

Is patient aware of diagnosis? Yes / No

Is patient aware of referral? Yes / No

REFERRER

Name .....

Job title .....

Contact details .....

.....

Date of referral .....

GP DETAILS

Name .....

Address .....

.....

..... Postcode .....

Tel .....

CURRENT HOSPITAL DETAILS

Hospital .....

Consultant .....

Patient's Hospital number .....

DISTRICT NURSE

Name .....

Based at .....

Tel ..... Fax .....

PALLIATIVE CARE TEAM (If known)

Name .....

Based at .....

Tel ..... Fax .....

ADDITIONAL INFORMATION
(i.e. other services involved, main carer contact details)

WHERE IS THE PATIENT AT PRESENT (Please tick)

☐ At home

☐ In Hospital: Ward name .....

Tel .....

☐ Elsewhere .....

Tel .....

URGENCY: ☐ Routine ☐ Urgent ☐ Very urgent

If not routine please state why:

CURRENT PROBLEMS REQUIRING SPECIALIST PALLIATIVE CARE INPUT

SERVICE REQUESTED

- ☐ Inpatient Unit
- ☐ Day Therapy
- ☐ Outpatient Service
- ☐ Community Palliative Care Team
- ☐ Hospice at Home

HISTORY OF ILLNESS AND TREATMENT

(Please enclose copies of relevant medical letters, blood results and investigation results)

MEDICATION (Please list or attach list)

Name of Drug	Dose	Frequency

MEDICATION (Please list or attach list)

Name of Drug	Dose	Frequency

DETAILS OF ANY RISK FACTORS FOR STAFF WHEN CARING FOR THIS PATIENT

IMPORTANT – Please enclose or send copies of all relevant letters and check that all sections are completed before sending; omissions may result in delays in processing your referral.

FORM COMPLETED BY

Name **Signature**

Name of Patient **Date of birth**