# 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** |
| Therapy Team | **01279 773 772** |

**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
- ☐ OT / PT
- ☐ 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**