# HHFT Logo 2017

# Winchester Community Palliative Care Service Referral Form

Please email to: [winchesterhospicereferrals@hhft.nhs.uk](mailto:winchesterhospicereferrals@hhft.nhs.uk)

\*New email as above from March 2023

Covering Winchester PCN (Frairsgate Surgery, St Clements Surgery and St Pauls Surgery)

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

|  |  |
| --- | --- |
| **Winchester Community Palliative Care**  **(Mon-Fri 08:30-16:30)**  **01962 825050** | **Winchester Hospice (24 hours)**  01962 825035 |

**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**

**GENERAL PRACTITIONER**

Name Dr: ……………..…..………………….….…

Surgery: …………………………………………..…

Telephone No: ……………………………...……

GP aware of referral: **YES / NO**

**NEXT OF KIN / MAIN CARER DETAILS** (if different)

Surname: …………………………………………………………………………………………..

First name: …………………………………………………………………………………………

Relationship: …………………………………………………………………………………….

Address: ……………………….………………………………………………………….………..

………………………………………………………………………………………………….….......

………………………………………………………………………………………………….………..

Telephone No: ……………………………… Mobile No: …………….………………….

**CURRENT LOCATION OF PATIENT (please tick)**

Home 🞏 Other 🞏...…….….………….

**REFERRER DETAILS**

Name: …………….…………………………………….…………..…..

Title: ……………….…………………………………….………..………

Department: ..………………………………………..……………….

Telephone No: ..…………………….…..……………………………

**Date of referral:**

…………….…………………..

**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**