**Ashgate Hospice Day Services Referral Form**

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| **Ashgate Hospice**Ashgate RoadOld BramptonChesterfieldDerbyshireS42 7JD | **Main reception:** 01246 568801 **Website:** [www.ashgatehospice.org.uk](http://www.ashgatehospicecare.org.uk)**Email:** clinical.admin@nhs.net |
| **Guidance: Please complete ALL sections below.****\*\*REFERRALS WILL NOT BE ACCEPTED IF THE REQUESTED INFORMATION IS INCOMPLETE\*\*****Please return completed forms to the email stated above.**  |
| **Patient Details** |
| **Patient’s name:** **Date of Birth:**  **NHS number:** **Address:** **Postcode:** **Tel:** **Mobile:** **Email:****Patient’s present location (IPU/Home/Hospital/Other)** **If hospital, please state where and planned discharge date:** **Would the patient be able to attend a clinic appointment?** Yes/No**Language spoken:**  **Communication needs:****Religion:**  | **Does the patient have a DNACPR/ReSPECT form in place?** Yes/No |
| **CONSENT**The information you share with us regarding the patient may be shared between other clinical services within the hospice and external services which may be beneficial to the care of the patient. Please specify below to confirm that the patient has consented to sharing information. **Has the patient been made aware and consented to the referral?**Yes/No**Is the referrer and patient aware of the criteria?** Yes/No |
| **As the referrer are you aware of any concerns about the patient’s mental capacity?** **Social Services involved?** Yes /No**Has a DS1500 been completed?** Yes/NoIf yes, please state where this can be found:SystmOne / DWP / Social Services/ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Does the patient have a Blue Badge?** Yes/No**Has the patient had a recent benefits check?** Yes/No |
| **Next of Kin/Preferred Contact** |
| Name: Relationship to patient: Tel: Mobile: Address: Email: |

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| **Diagnosis details** |
| **Primary diagnosis: Date of diagnosis:** **Metastases: Date of metastatic diagnosis:** |
| **Past Medical History****Do you have any concerns about family circumstances/ carers?**  | **Allergies** |
| **Does the patient require oxygen?** Yes/No**Are there any difficult family circumstances?** Yes/No**If yes, please state:**  |
| **Reason for referral** |

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| **\*\*If a referral is accepted a personalised care plan will be developed\*\***(Please refer to our criteria for more guidance on this section)**Please list the patients 3 main problems/concerns:**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What are you hoping can be achieved by this referral to Day Services?** **Any other supporting information that is relevant to the referral:** |
| **Referrer details** | **GP/District Nurse Details** |
| Name: Job title: Contact number:Email address: Base:**How did you hear about us?**  | Named GP: Address: Postcode: Tel: District Nurse:Tel:  |