** Ashgate Hospice Inpatient Unit Referral Form   
GUIDANCE:** Please complete **all sections** below.   
Referral criteria can be found on our website.  
Please return completed forms to the email stated below or Fax.

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| **Ashgate Hospice**  Ashgate Road  Old Brampton  Chesterfield  Derbyshire, S42 7JD | **Main reception:** 01246 568801  **Inpatient Unit referrals email:** ashgate.wardtriage@nhs.net **Fax:** 01246 565043  **Website:** www.ashgatehospice.org.uk |
| **Date of referral:** | **Time:** |
| **Is the patient at home or currently an inpatient?**  **If hospital, please state where: Tel:** | |

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| **Referrer details** | **GP/District Nurse Details** |
| Name:  Job title:  Contact number  Email address:  Base: | Named GP:  Address:  Postcode:  Tel:  District Nurse:  Tel: |

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| **Patient Details** | | |
| Patient’s name:  Date of Birth:    NHS number:    Gender:  Address:  Postcode:  Tel:  Mobile: | | Language spoken: Interpreter required? YES/NO  Religion:  **Does the patient have a DNACPR 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 consented to the referral?** Yes/No  **Is the patient aware of the referral?**  Yes/No |
| **Professional/Consultant involvement**  Name:  Location:  Tel: |
| **Next of Kin/Preferred Contact** | | |
| Name: Relationship to patient:  Tel: Mobile:  Address: | | |
| **Diagnosis details** | | |
| Diagnosis: Date of diagnosis:  Metastases: Date of metastatic diagnosis: | | |
| Is the patient currently receiving any treatment such as chemotherapy/radiotherapy/immunotherapy? | Allergies | |

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| **Reason for referral** (Please send a copy of the GP summary, current medication, recent blood and investigative results to process the referral) | |
| **Please provide detailed reason for the referral below.** | |
| **Specialist needs (please circle and give more details)** | |
| Oxygen    CPAP/NIV/Cough Assist  PICC/Hickman line  Catheter | Syringe Driver  Infection  PEG    Mobility |

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| **Additional information** |
| Please provide any other information that may be useful to process the referral e.g. social work involvement, or any other risk factors associated with the patient’s care. |