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| **ASHGATE HOSPICE PHYSIOTHERAPY TEAM** | | | | | | |
| **Please tick to indicate the priority of this referral:**  Physiotherapy service operates Mon-Fri 8.30am-4.30pm  **EMERGENCY** (within 4hrs) **URGENT** (within 48hrs working days)  **DETERIORATING** (within 5 working days)  **ROUTINE (within** 10 days)  **If the referral is EMERGENCY OR URGENT, please state reason why:** (Please see **Referral Criteria** for further information) | | | | | | |
| **GUIDANCE: Please complete all relevant sections below. Please email completed form and relevant documentation to:** [clinical.admin@nhs.net](mailto:clinical.admin@nhs.net) **Clinical Admin Team contact Tel: 01246 565026 9.00am – 17.00pm**  **REFERRALS WILL NOT BE ACCEPTED IF INFORMATION REQUESTED IS NOT COMPLETED OR IF THE PATIENT REFUSES TO CONSENT** | | | | | | |
| **Date of referral:** | | **Name of referrer:**  **Job Title:** | | | **Base of Work:** | |
| **Email:** | | | | **Contact telephone:** | | |
| **Base of work:** | | | | | | |
| **HAS THE PATIENT CONSENTED TO THE REFERRAL AND AGREED TO SHARING THEIR HEALTH RECORDS?**  **YES  NO** | | | | | | |
| **Is the District Nursing team involved in the patients care?**  **YES  NO** | | | | | | |
| **Has the patient been previously known to Ashgate Hospice?**  **YES  NO** | | | | | | |
| **What is the patients current location:** | | | | | | |
| **PATIENT DETAILS** | | | | | | |
| **Name of patient:** |  | | | | | |
| **NHS number:** | | | **Date of birth:** | | | **Age:** |
| **Address:** | | | | | | |
| **Contact Tel:** | | | | **Mob:** | | |
| **Is English their first language? YES  NO**  **If NO, what is their preferred language:**  **Ethnicity:**  **Marital status:** | | | | **Does the patient live alone? YES  NO**  **Key safe:**  **Religion:** | | |
| **NEXT OF KIN/PREFERRED CONTACT** | | | | **OTHER RELEVANT FAMILY MEMBER** | | |
| **Name:**  **Relationship:**  **Address:**  **Contact Tel:**  **Mob:** | | | | **Name:**  **Relationship:**  **Address:**  **Contact Tel:**  **Mob:** | | |
| **GP AND DISTRICT NURSE TEAM** | | | | | | |
| **Named GP:**  **Surgery:**  **Tel:**  **Is GP aware of referral?**  YES  NO | | | | **District Nurse:**  **Tel:** | | |
| **OTHER PROFESSIONALS INVOLVED** | | | | | | |
| **Name of Hospital Consultant:**  **Base:**  **Contact no:** | | | | **Additional professions if known:**  **Base:**  **Contact no:** | | |
| **Palliative Care Consultant/CNS:** | | | | **Social Services involved: Yes  No  Unknown**  **Care Manager:** | | |

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| **DIAGNOSIS, TREATMENT AND PAST MEDICAL HISTORY:** | |
| **Primary Diagnosis:**  **Date of Diagnosis** | |
| **Metastases:**  **Date of Diagnosis:** | |
| **Past Medical History:** | |
| **PLEASE STATE DETAILED REASON FOR REFERRAL INCLUDING CURRENT SYMPTOMS AND FUNCTIONAL DIFFICULTIES:** | |
| **EQUIPMENT ALREADY IN THE HOME (PLEASE STATE):** | |
| **Is the patient currently having any treatment/investigations?** | |
| **Does the patient have any mobility, disability, communication, or language issues?** | |
| **Has a DS1500 been completed? YES  NO  UNKOWN** | |
| **HOME RISK ASSESSMENT** | |
| **Are there any Hazards in the home?**  **YES  NO  UNKNOWN**  **If YES please state:**  **Are there any pets in the home?**  **YES  NO  UNKNOWN**  **If YES please state:** | **Are there any smokers in the home?**  **YES  NO  UNKNOWN**  **Any past episodes of aggression or violence?**  **YES  NO  UNKNOWN**  **Are their any difficult family circumstances?**  **YES  NO  UNKNOWN**  **If YES please provide more information:** |
| **DOCUMENTATION** | |
| **Please tick which documentation you have included with the referral:**  **List of current medication  Latest clinic letter  Latest letter from GP**  **GP Summary Past Medical History  DS1500 Form  Relevant investigation and results**  **PLEASE NOTE THAT YOU MUST INCLUDE A CURRENT LIST OF MEDICATION AND AT LEAST ONE MORE OF THE ABOVE DOCUMENTATION WITH THE REFERRAL TO BE ACCEPTED AND AVOID DELAY.** | |