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**Ashgate Hospice Supportive Care Services Referral Form**

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| **Ashgate Hospice**Ashgate RoadOld BramptonChesterfieldDerbyshireS42 7JD | **Main Reception:** 01246 568801 **Website:** www.ashgatehospice.org.uk**Email:** supportivecarereferrals@ashgatehospice.org.uk |
| **Guidance: Please complete ALL sections below.****\*\*REFERRALS MAY NOT BE ACCEPTED IF THE REQUESTED INFORMATION IS INCOMPLETE\*\*****Please return completed forms to the email stated above.**  |

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| **CLIENT DETAILS:** |
| **Name:** **DOB:** **Please ensure DOB is entered.** **Address:** **Contact No:**  | **NHS No:****GP Details:** |
| **Is the client a patient? YES/NO** **If Yes, please state the nature of the illness – provide more detailed information:** |
| **Is the client aware of the referral to Supportive Care Service? YES/NO** **If No, please state the reason:** |
| **If this person is caring for a person receiving palliative care, please provide that person’s name and relationship to the client you are referring:**  |
| **REASON FOR REFERRAL:** |
| 1. **Presenting issue/precipitating event:**
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| 1. **Effect on personal and work life/emotional wellbeing:**
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| 1. **Please provide information about specific cultural/health/language needs, etc that need to be taken account of:**
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| 1. **Identify any risk factors – ie: household members, pets, infection control:**
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| 1. **What benefit do you think Supportive Care Service involvement will bring to the client?**
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| **DETAILS OF REFERRER:** |
| **Name:** | **Date of Referral:**  |
| **Job Title:** **Base** |  |
| **Contact Details:****Mobile No****Email Address** |