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**Ashgate Hospice Supportive Care Services Referral Form**

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| **Ashgate Hospice**  Ashgate Road  Old Brampton  Chesterfield  Derbyshire  S42 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:** | |
| 1. **Effect on personal and work life/emotional wellbeing:** | |
| 1. **Please provide information about specific cultural/health/language needs, etc that need to be taken account of:** | |
| 1. **Identify any risk factors – ie: household members, pets, infection control:** | |
| 1. **What benefit do you think Supportive Care Service involvement will bring to the client?** | |
| **DETAILS OF REFERRER:** | |
| **Name:** | **Date of Referral:** |
| **Job Title:**  **Base** |  |
| **Contact Details:**  **Mobile No**  **Email Address** |