

**ASHGATE HOSPICE VIRTUAL WARD TEAM**

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| **REFERRALS WILL NOT BE ACCEPTED IF INFORMATION REQUESTED IS NOT COMPLETED OR IF THE PATIENT REFUSES TO CONSENT** | | | | | | | |
| **GUIDANCE: Please complete all relevant sections below. Please email completed form and relevant documentation to:** [ashgatehospice.referrals@nhs.net](mailto:ashgatehospice.referrals@nhs.net)    **For urgent queries, please contact 01246 565030 9.00am – 17.00pm** | | | | | | | |
| **Date of referral:** | | **Name of referrer:**  **Job title:** | | | | **Base of work:** | |
| **Email:** | | | | **Contact telephone:** | | | |
| **Referrer’s availability to be contacted:** | | | | | | | |
| **HAS THE PATIENT CONSENTED TO THE REFERRAL AND AGREED TO SHARE THEIR HEALTH RECORDS?**  **YES  NO** | | | | | | | |
| **Is the District Nurse involved in the patient’s care? Yes  No**  If no, please make a referral to the District Nursing Team. | | | | | | | |
| **Has the patient been known previously to Ashgate Hospice? Yes  No**  If yes, please state which services: | | | | | | | |
| **Patient’s current location:** | | | | | | | |
| **PATIENT DETAILS** | | | | | | | |
| **Name of patient** |  | | | | | | |
| **NHS number:** | | | **Date of birth:** | | | | **Age:** |
| **Address:** | | | | | | | |
| **Contact Tel:** | | | | | **Mobile:** | | |
| **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 NURSING TEAM** | | | | | | | |
| **Named GP:**  **Surgery:**  **Tel:**  **Is GP aware if referral? Yes  No** | | | | | **District Nurse:**  **Tel:**  Please refer to the District Nursing Team if you have not already done so. | | |
| **OTHER PROFESSIONALS INVOLVED** | | | | | | | |
| **Name of Hospital Consultant:**  **Base:**  **Contact Tel:** | | | | **Additional Professional if known:**  **Base:**  **Contact Tel:** | | | |
| **Palliative Care Consultant/CNS:** | | | | **Social Services involved?**  **Care Manager:** | | | |

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| **DIAGNOSIS, TREATMENT AND PAST MEDICAL HISTORY** | | |
| **Primary(ies) Diagnosis:**  **Date of Diagnosis:** | | |
| **Metastases:**  **Date of Diagnosis:** | | |
| **Past Medical History:**  **Allergies: Yes  No  Unknown  If yes, please state:** | | |
| **PLEASE STATE DETAILED REASON FOR REFERRAL INCLUDING CURRENT SYMPTOMS:** | | |
| **Is the patient currently having any treatment/investigations?** | | |
| **Does the patient have any mobility, disability, communication/language issues?** | | |
| **Has a DS1500 been completed?**  **Yes  No  Unknown** | | |
| **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/violence?**  **Yes  No  Unknown**  **Are there 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**  **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.** | | |
| **Date of discharge** | **Date/Place of death** | |
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