

 **ASHGATE HOSPICE VIRTUAL WARD TEAM**

|  |
| --- |
| [x]  [x]  **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  **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:** |

|  |
| --- |
| **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** |
|  |  |