**St Richard’s Hospice Patient Referral From**

Wildwood Drive, Worcester, WR5 2QT Tel 01905 763963

Referral Email srhgateway.referrals@nhs.net

**PLEASE COMPLETE BOTH SIDES- ALL REFERRALS WILL BE ASSESSED BY THE GATEWAY TEAM**

**FOR BEREAVEMENT SUPPORT SOUTH WORCESTERSHIRE PLEASE COMPLETE SECTION 1, 2, 3 & 5**

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| **SECTION 1:PATIENT / CLIENT DETAILS** |
| Surname:\*First name:\*Known as:D.O.B:\*Marital status:Address:\*Postcode:\*Tel No:\*Mobile No:NHS Number:\*Occupation:Religion:Ethnic Group:Patient consent to referral:\* Yes / NoPatient has mental capacity:\* Yes / NoRelative consent to referral:\* Yes / No**Without consent the referral cannot be accepted** | Next of Kin:\*Relationship:\*Parental responsibility if BSSW client under 18  \* Yes / NoAddress:Postcode:Tel no:Mobile no: |
| Main carer if differentName:Address:Post code:Tel no:Mobile no: |

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| **SECTION 2: PROFESSIONAL DETAILS** |
| **GP details**Name:\*Address:\*Telephone number:\*GP Email address:\* | **Other professionals involved**District Nurse Team contact Number:Consultant name and telephone number:Social Worker name and telephone number:Other: |

\*Denotes a mandatory field

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| **SECTION 3:REASON FOR REFERRAL** | **SECTION 4- MEDICAL DETAILS** |
| Reason for referral :-* **Community Support**:

 End of life care [ ] Emotional / Psychological support [ ] Pain / Symptom support [ ] Carer Support [ ]* **Living well Centre** [ ]
* **Inpatient unit admission:**

 End of Life Care [ ] Emotional / Psychological Support [ ] Pain / Symptom support [ ] Carer Support [ ]* **Bereavement Support South Worcestershire**: [ ]

 Name of deceased Date of Death Relationship to person referred Nature of death : expected /unexpected/sudden Permission to leave messages on the phone Y/N* **Outpatient clinics**

End stage renal failure [ ]Cardiac [ ]Non-malignant Respiratory [ ]Parkinsons [ ] | **Diagnosis :****Date of Diagnosis:****Patient and family insight:****Previous medical history:****Preferred place of care**:Home / Hospice / Hospital / Not known **Preferred place of death**:Home / Hospice / Hospital / Not known **ReSPECT DOCUMENTATION** Yes/ No**DNACPR**: Yes / No**JIC medication prescribed** Yes / No |
| **SECTION 5- CURRENT PROBLEMS / PRESENTING ISSUES** |
| Current problems and aims for referral: |
| **Please attach the following documents to support this referral if available. NOT FOR BSSW REFERRALS** |
| GP summary  |  **Y/N** |
| Medication list | **Y/N** |
| Clinic letters from outside of Worcestershire area for past 6 months | **Y/N** |

**Further referral forms available via our website at :** <https://www.strichards.org.uk/education/referrals/how-to-make-a-referral/>

Referrer Name: (Please print)\*………………………………… Designation:\* ……………………………Date: ……………………..

Tel no:\*…………………………………. Mobile no :…………………………………… Email\*: …………………………………………….