**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 / No  Patient has mental capacity:\* Yes / No  Relative consent to referral:\* Yes / No  **Without consent the referral cannot be accepted** | Next of Kin:\*  Relationship:\*  Parental responsibility if BSSW client under 18  \* Yes / No  Address:  Postcode:  Tel no:  Mobile no: |
| Main carer if different  Name:  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\*: …………………………………………….