SPECIALIST PALLIATIVE CARE SERVICES
IN BRADFORD, AIREDALE, WHARFEDALE & CRAVEN

COMMON REFERRAL FORM

Specialist palliative care services across the Bradford, Airedale and Craven district offer multi-professional care to people with any advanced, progressive, incurable illness – not just those with cancer.

Use this form to make a referral to any of the services listed below. Please complete in full with black ink and send it to the appropriate service. This will help us to provide prompt, effective care.

Please note:

1. Home assessment/support is provided by the Community Palliative Care Team in the Bradford area, by Sue Ryder Manorlands in the Airedale/Craven/Wharfedale area.

2. Both hospices also offer inpatient care (for symptom control, rehabilitation or terminal care) day therapy and medical outpatient assessment.

3. The service expects the patient, their GP and District Nurse to be informed that a referral has been made. For hospital inpatients, the responsible consultant should also be aware of the referral.

Which service are you referring the patient to? (Please tick)

<table>
<thead>
<tr>
<th>Bradford Community Palliative Care Team</th>
<th>Tel 01274 221151</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based at Shipley Health Centre,</td>
<td></td>
</tr>
<tr>
<td>Alexandra Road, Shipley  BD18 3EG</td>
<td></td>
</tr>
<tr>
<td>Email: Fax-HPK/Admin-Hub@bdct.nhs.uk</td>
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<thead>
<tr>
<th>Sue Ryder Manorlands Hospice</th>
<th>Tel 01535 642308</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hebden Rd, Oxenhope  BD22 9HJ</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:admin.manorlands@nhs.net">admin.manorlands@nhs.net</a></td>
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<table>
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<tr>
<th>Marie Curie Hospice, Bradford</th>
<th>Tel 01274 337000</th>
</tr>
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<tbody>
<tr>
<td>Maudsley St Bradford BD3 9LE</td>
<td></td>
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<tr>
<td>Email: <a href="mailto:mariecuriebradford@nhs.net">mariecuriebradford@nhs.net</a></td>
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Revised January 2020
SPECIALIST PALLIATIVE CARE REFERRAL FORM

PATIENT DETAILS
Surname……………………. First name(s).......................... DOB........................................
Tel........................................ NHS No. .................................
Home address.......................................................... Post Code......................................

Where is the patient at present? ..........................................................
First language (if not English): ........................................ Is an interpreter necessary? Yes □ No □
Sex:  Male □ Female □ Lives Alone Yes □ No □

PLEASE ASK THE PATIENT FOR CONSENT TO SHARE THEIR GP RECORD WITH THE PALLIATIVE CARE SERVICE

Shared care granted: Yes □ No □

WHAT IS THE REFERRAL FOR?

Home assessment / support □ Medical outpatient assessment □
Hospice admission □ Day therapy □ Psychological needs □

How quickly does this patient need to be seen?
Within 2 working days □ Give reason: Severe physical symptoms □ Severe psychological distress □
3-5 working days □
1-2 weeks □
Please confirm that the patient is aware of the referral: Yes □ No □

DETAILS OF MAIN CARER

Name........................................... Address..............................................................
Tel........................................... Relationship to patient...........................................
Details of next of kin (if different from above): ..............................................................

PROFESSIONALS INVOLVED

Name
General Practitioner: ..............................................................
District Nurse: ..............................................................
Others e.g Specialist Nurses, Social Worker or Community Matron

...
PATIENT’S NAME

DISEASE STATUS

Diagnosis ........................................................................ Date of diagnosis ..........................
Sites of metastases (if malignancy) ..............................................................
Past/current disease management (send copies of discharge summaries, correspondence etc) ..................................

Relevant past medical history ........................................................................

On GP Gold Standards Framework? Yes □  No □  Don’t know □

What has the patient been told about their illness?

What have the family/carers been told about the illness?

CURRENT PROBLEMS

What are the problems you want the palliative care service to help with?
Please give details of
Uncontrolled symptoms or physical problems

Psychosocial issues

Needs of carers or other family members

Additional relevant information
Continue overleaf or attach letters etc as appropriate

REFERRING PERSON

Name (please print) ..............................  Designation ............................. Date.............................

Address..............................................  Tel............................. Signature .............................