Referral Form

Colne Road, Reedley, Burnley, BB10 2LW Tel: 01282 440100 Fax: 01282 440123

Please complete as fully as possible to avoid delay in referral to the service.

Before completing please confirm that:

The patient's consent to the referral has been obtained (please circle answer)	**Yes**	**No**
The patient has agreed to sharing of healthcare information (please circle answer)	**Yes**	**No**

Name		Date of Birth		Age	
Address (incl. postcode)		Marital Status			
		Ethnicity			
		NHS Number			
		Current location of patient:			
		Lives alone	Yes	No	
Telephone number		Mobile number			
Diagnosis		Date of Diagnosis			
Site of Metastases		Allergies			

Referral Priority:	Urgent ☐	Soon ☐	Routine ☐		
Referral for:					
INPATIENTS					
Assessment ☐	Symptom Control ☐	Rehabilitation ☐	Last days of life ☐		
HOSPICE at HOME					
Hospice at Home ☐	Extended Service ☐	PenPals Volunteers ☐			
DAY SERVICES					
Day Services ☐	Complementary Therapy ☐	Physiotherapy ☐			
Psychological Support ☐	Information & Resource Clinic (Drop In) ☐				
MEDICAL	Medical Outpatients Clinic ☐	Medical Home Visit ☐			
FAMILY SUPPORT	Counselling ☐	Spiritual Care ☐	Complementary Therapy ☐		

Reason for Referral (Including current situation and problems)

Treatment		**Relevant Past Medical History**
Surgery:		
Chemotherapy:		
Radiotherapy:		
Hormone Treatment:		

*Please enter N/A if any of the above questions are not applicable.

Name	
Current Medication	
Next of Kin (name and address)	Relationship to patient
	Telephone no:
	Mobile no:
Main Carer (if different to Next of Kin)	Relationship to patient
	Telephone no:
	Mobile no:
Patient's GP	Telephone no:
Patient's Consultant	Telephone no:
District Nurse	Telephone no:
Macmillan Nurse	Telephone no:
Social Worker	Telephone no:
Other	Telephone no:
Current support provided by professional(s)	
Name of Referrer (Block Capitals)	Position
Telephone no:	Mobile no:
Signature	Date