IHCRS Referral Form

Patient has consented to referral: **Mandatory - Enter YES or NO**

Patient Details

Title First Name Surname

Gender
NHS Number
Date of Birth
Phone
Mobile Phone

Address Line 1
Address Line 2
Address Line 3
Address Line 4
Post Code

Current place of care: HOME/ HOSPITAL/ NURSING HOME/ RESIDENTIAL HOME

Patient lives alone: YES/NO

Patient able to travel to OPA: YES/NO

Transport requirements

Primary Diagnosis(es) and key treatments

Diagnosis 1
Diagnosis 2
Diagnosis 3
Treatment

Palliative stage of illness? YES/NO

Service Requested

Pilgrims Therapy Centre (please specify programme)

Community/outpatient care

Hospice Admission

Rapid response hospice at home to enable dying at home

Problem(s) to be addressed

End of Life Care (actively dying in days)
Physical symptom control
Psychological / Social Support
Other

Special Considerations

Communication difficulties: Enter YES or NO
Infection status
Safeguarding issues (*e.g.* AP1)
Other

Next of Kin / Main Carer

Title | First Name | Surname

Relationship to patient

Phone
Mobile Phone

Address Line 1
Address Line 2
Address Line 3
Address Line 4
Post Code

General Practitioner

Title | First Name | Surname

Surgery
Phone
Mobile
Fax
Email

Address Line 1
Address Line 2
Address Line 3
Address Line 4
Post Code

Urgency of Referral

Urgency

Options:
Emergency TODAY – please phone 01233 504133
Urgent 1- 2 DAYS – please state reason
Routine Up to 7 DAYS

Medication

Allergies

Sensitivities

Please attach supporting Clinical information: enter **YES** below as appropriate

Recent hospital letters/discharge letter
Medication list/TTOs
Short summary of GP record

Person completing this form:

Name | Designation | Date
Telephone | Email

Advance care planning:

Ceilings of treatment agreed
Preferred place of death
DNACPR completed: Enter YES or NO
Palliative Care Register/Electronic Palliative Care Coordination System *(e.g.* Share My Care EOL record):

Email to:

For queries ring:

01233 504133