Severn Hospice

REFERRALS TO SEVERN HOSPICE SERVICES

Severn Hospice Shrewsbury – Bicton Heath, Shrewsbury, Shropshire, SY3 8HS
Tel: 01743 236565 Fax: 01743 261512 E-mail: sth-tr.referrals.severnhospice@nhs.net

Severn Hospice Telford – Apley Castle, Telford, Shropshire, TF1 6RH
Tel: 01952 221350 Fax: 01952 221360 (In-patient and all other services) 01952 221363 (CNS Team)
E-mail: sth-tr.referrals.severnhospice@nhs.net

Severn Hospice Hafan – Hosbis Hafren, Severn Hospice, Back Lane, Newtown, Powys, SY16 2NH
Tel: 01686 623558

Severn Hospice – Ceredigion, Tŷ Geraint, Aberystwyth, SY23 1ER
Tel: 01970 635790 Fax: 01920 628859

From this information we will prioritise this referral.

Please complete all fields.

Service Referring To:

○ In-patient Unit ○ CNS Team ○ Day Hospice ○ Domiciliary Visit

○ Out-patient Clinic: Lymphoedema / Breathlessness / MND / Medical / Complementary Therapy
(Please indicate which clinic)

Referred By: ____________________________ **Position:** __________________________________

Contact Number: ________________ **Date Referred:** __________ **Date Contacted:** ______________

PATIENT DETAILS

Patient Name: ___________________________ **Date of Birth:** ________________ **Age:** ______

Address: ____

Telephone Number: _____________________ **Male/Female:** ____________________________

Marital Status: __________________________ **Ethnic Group:** _____________________________

Next of Kin: ______________________________ **Relationship to Patient:** ____________________

Address (if different) ____

Contact Number: _______________________

GP: ___________________________________ **Practice:** ___________________________________

Address/Contact Number: ____

Relevant Family Issues: ____

Current Location of Patient: ____

NHS Number: ____________________________ **Hospital Number:** ______________________________

Has the patient agreed to this referral? Yes / No

Is the patient's carer aware of referral? Yes / No

What is the patient/carers understanding? ____

MEDICAL INFORMATION

(Please provide supporting medical information (i.e. RCR2, recent oncology letters etc.)

Diagnosis: ______________________________________ **Date of Diagnosis:** ___________________

Consultant/Other Professionals Involved: ____

Disease Progression **(e.g. Mets):** ____

____

Treatments/Investigations: ____

____

Is the patient for further active treatment: Yes / No

Details: ____

Is the patient in the palliative phase of their illness: Yes / No

Has DNAR been discussed: Yes / No **Outcome of discussion:** ______________________________

Relevant Medical History:

Current Medication:

CURRENT NEEDS/SYMPTOMS

Please comment on symptoms, changes in circumstances and family carer support.

FOR OFFICE USE ONLY

PLAN – Reason for Decision/Outcome

○ **Urgent** ○ **Non-Urgent**