Severn Hospice here and at home

REFERRALS TO SEVERN HOSPICE SERVICES

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

Severn Hospice Telford – Apley Castle, Telford, Shropshire TF1 6RH
Tel: 01952 221350 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: 01970 628857

From this information we will prioritise this referral.

Please complete all fields.

Service Referring To:

☐ In-patient Unit ☐ Outreach Team ☐ Day Services ☐ 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/carer's 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