REFERRALS TO SEVERN HOSPICE SERVICES

From this information we will prioritise this referral.

Please complete all fields.

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

Severn Hospice Telford – Apley Castle, Telford, Shropshire, TF1 6RH
Tel: 01952 221350 Fax: 01952 221360
E-mail: severnhospice.referrals@nhs.net

Severn Hospice Hafan – Hosbis Hafren, Severn Hospice, Back Lane, Newtown, Powys, SY16 2NH
Tel: 01686 623558 Fax: 01686 611037

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

Service Referring To:

○ Outreach Team ○ Day Services ○ Domiciliary Visit (Medical)

○ 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**