REFERRALS TO SEVERN HOSPICE SERVICES

Severn Hospice Shrewsbury – Bicton Heath, Shrewsbury, Shropshire, SY3 8HS
Tel: 01743 236565 Email: severnhospice.referrals@nhs.net

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

From this information we will prioritise this referral.

Please complete all fields.

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/carer's understanding? _____

MEDICAL INFORMATION

(Please provide supporting medical information (Eg RCR2, recent oncology letters etc)

Diagnosis: _____ Date of diagnosis: _____

Consultant/other professionals involved: _____

Disease progression (Eg 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