

Adult Specialist Palliative Care Referral Form –Version 1.2

All sections of this form must be completed to ensure that the process is not slowed down by services having to check details with the referrer. If a section is not relevant put 'Not Applicable'.

**All referral forms must be sent to the specialist teams, who will assess what level of input is appropriate.
Please send copies of recent clinical correspondence with the form**

Providers can be located via the Palliative Care Directory – www.birminghamcancer.nhs.uk

Criteria for Referral:	The patient has a diagnosis of advanced life limiting illness and;
<ul style="list-style-type: none"> • symptom control or other complex problems, which are escalating or are unable to be managed by the current clinical team. These symptoms may be physical, psychological, spiritual, social, or family and carer orientated issues. • complex social needs resulting from their illness or whose families show exceptional emotional distress. • Prior to referral patients with capacity must consent. Referral must be judged to be in the best interests of patients who lack capacity. 	

Patient details			
NHS Number:	Patient consents to Specialist Palliative Care involvement: Yes <input type="checkbox"/> No <input type="checkbox"/> Unable <input type="checkbox"/> <i>If No please give details on next page.</i>	Office use	
Surname:	Male / Female	DoB / Age:	
First Name:		Marital Status:	
Address:	Ethnicity:		
	Religion:		
Post Code:	Telephone:	Mobile:	

Referrer's signature:	Name (please print):		
Job title:	Contact number:	Bleep No:	
Surgery or Hospital:		Date:	

Next of kin/patient representatives	District Nurse: Involved Yes <input type="checkbox"/> No <input type="checkbox"/>	General Practitioner: Informed Yes <input type="checkbox"/> No <input type="checkbox"/>
Name:	Name:	Name:
Address:	Based at:	Address:
	Telephone:	
	Fax:	Post code:
Telephone:	Social Services: Involved Yes <input type="checkbox"/> No <input type="checkbox"/>	Telephone:
Mobile:	Name:	Fax:
Relationship to patient:	Based at:	Email:
Main Carer (if different from above)	Telephone:	On practice GSF Register: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Name:	Fax:	Continuing health care assess. completed: Yes <input type="checkbox"/> No <input type="checkbox"/> Funding Agreed <input type="checkbox"/>
Telephone:	Other professionals involved:	
Mobile:		
Relationship to patient:		

Communication First language if not English: Would an interpreter be helpful to patient or palliative care staff? Yes <input type="checkbox"/> No <input type="checkbox"/>	Communication in English (please tick) Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
Other barriers to communication, eg. hearing loss, confusion.	

