st oswald's hospice
quality time for everyone
celebrating #30yearsofcare

ST OSWALD'S HOSPICE FOCUS ON LIVING CENTRE REFERRAL FORM

<table>
<tr><td>Title</td><td colspan="2">Surname</td><td>First name</td><td>Preferred name</td></tr>
<tr><td>DOB</td><td>Age</td><td>Sex
Male ☐ Female ☐</td><td>NHS Number</td><td>Date of Referral</td></tr>
<tr><td colspan="3" rowspan="2">Address

Postcode</td><td>Telephone Number</td><td>Lives alone
Yes ☐ No ☐</td></tr>
<tr><td>Ethnic Group

Interpreter required
Yes ☐ No ☐</td><td>Religion</td></tr>
<tr><td colspan="3">NOK details / Main carer

Full name

Address

Telephone Number (mobile)

Relationship</td><td colspan="2">Referred by

Designation

Contact

Consent agreed for referral
Yes ☐ No ☐

*please note referral will not be accepted if patient or main carer has not consented to referral</td></tr>
<tr><td colspan="3">Diagnosis
Primary:

Secondary:

Date</td><td colspan="2" rowspan="2">GP

Address

Telephone Number</td></tr>
<tr><td colspan="3">Known to Social Services
Yes ☐ No ☐</td></tr>
<tr><td>Macmillan Nurse</td><td colspan="2">Telephone Number</td><td>District Nurse</td><td>Telephone Number</td></tr>
<tr><td>Clinical Nurse Specialist</td><td colspan="2">Telephone Number</td><td>Consultant</td><td>Telephone Number</td></tr>
<tr><td colspan="3">Reason for referral:</td><td colspan="2"></td></tr>
<tr><td>☐ Pain /Symptom management (please specify symptoms)</td><td colspan="2">☐ Psychological/ Emotional support</td><td>☐ Spiritual support</td><td>☐ Social Support</td></tr>
<tr><td colspan="3"></td><td colspan="2">☐ Other (please specify)</td></tr>
<tr><td colspan="5">Please indicate which services person may be interested in attending (tick all that apply)</td></tr>
<tr><td>☐ Carer support</td><td>☐ Breathlessness management</td><td>☐ Family support team / counselling</td><td colspan="2">☐ Fatigue management (group session)</td></tr>
<tr><td>☐ Occupational Therapy</td><td>☐ Complementary therapies</td><td>☐ Physiotherapy</td><td colspan="2">☐ Creative writing (group session)</td></tr>
<tr><td>☐ Social Worker</td><td>☐ Arts and Crafts</td><td>☐ Nursing support</td><td colspan="2">☐ Relaxation therapies (group session)</td></tr>
</table>

☐ Tripudio (group session)	☐ Acupuncture	☐ Positive Steps programme	☐ Day Hospice
☐ Restorative yoga (group session)	☐ Talking therapies	☐Psychology/ Wellbeing	

Advanced decisions/statements

EHCP Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
LPA Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
DNACPR Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐

Any other advanced decisions/statements completed or disclosed

Relevant medical history, including medication, allergies and any current nursing interventions

Any cognitive impairment and/or sensory impairment. If yes please provide relevant information

Can Mental Capacity be assumed? If No- what is the reason for needing to assess capacity

Any relevant information including the situation leading up to this referral

Additional information

☐ Assistance needed with medication?	☐ PEG	☐ Oxygen therapy	☐ Syringe Driver
☐ Wounds/pressure damage?	☐ Known infection?	☐ Seizure activity	

If yes to any of the above, or any other relevant information please comment below