

IF NOT ROUTINE PLEASE STATE WHY:

CURRENT PROBLEMS REQUIRING SPECIALIST PALLIATIVE CARE INPUT

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SERVICE REQUESTED

HOSPICE	In-Patient Unit	<input type="checkbox"/>	Day Therapy	<input type="checkbox"/>	Outpatient Service	<input type="checkbox"/>
MACMILLAN TEAM	Hospital In-Patient	<input type="checkbox"/>	Community Support Team	<input type="checkbox"/>	Equipment Loan	<input type="checkbox"/>

HISTORY OF ILLNESS AND TREATMENT (please enclose copies of relevant medical letters, blood results and investigation results)

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No need to complete if referral is for equipment

MEDICATION (Please list or attach list)

NAME OF DRUG	DOSE	FREQUENCY	NAME OF DRUG	DOSE	FREQUENCY.....
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DETAILS OF ANY RISK FACTORS FOR STAFF WHEN CARING FOR THIS PATIENT

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IMPORTANT – PLEASE ENCLOSE OR SEND COPIES OF ALL RELEVANT LETTERS AND CHECK THAT ALL SECTIONS ARE COMPLETED BEFORE SENDING; OMISSIONS MAY RESULT IN DELAYS IN PROCESSING YOUR REFERRAL

FORM COMPLETED BY

NAME SIGNATURE.....

NAME OF PATIENT..... DATE OF BIRTH..... NHS No.