Office use:	iCARE:	Canisc:	CWS:	Version 3.01/2014. Review 01/2014

Hospice of the Valleys Referral Form

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Ideally all the following information should be available from the referrer. As an absolute minimum, all the information on the left hand column is required before the referral can be processed. **The referral can not be accepted until all the mandatory information is available**.

REFERRAL	Date of referral:	
	Priority of referral: [ ] **Routine** *(2-7 days)* [ ] **Urgent** *(24-48 hours)*	
PATIE NT AND CARERS DETAILS	Patient's name:	Main carer: Relationship: Address: Telephone:
	Patient's address and postcode:	
	Patient's date of birth:	SOCIAL SITUATION (e.g. lives alone, whether mobile):
	Patient's telephone number:	
PROFESSIONALS	GP: Address: Telephone number:	Other professionals patient known to (name and contact number where available): [ ] Hospital consultants: [ ] District nurses: [ ] Social services: [ ] OT: [ ] Physio:
	GP aware of referral [ ] Yes [ ] No [ ] Not known	
	Any known safety/risk/lone worker issues for professionals visiting at home?	Risk management strategies if any known issues for professionals visiting at home:
CLINICAL INFORMATION	Main life-limiting diagnosis:	Date of diagnosis:
	Is the patient aware of: (a) Diagnosis: [ ] YES [ ] NO [ ] UNSURE (b) Referral to HotV: [ ] YES [ ] NO [ ] UNSURE *Explanation if "no" or "Unsure" e.g. advanced dementia:*	Severity and/or extent of disease: Patient aware of prognosis: [ ]YES [ ]NO [ ]UNSURE
	Reason for referral: [ ] Symptom control [ ] End of Life Care [ ] Psychological support for patient [ ] Psychological support for carer [ ] **Hospice @ Home** [ ] Other: [ ] **Current location of patient** Current problem/reason for Hospice involvement:	Other medical diagnosis: Medication: OFFICE USE: **Referral taken by/date/time:** **Referral reviewed by/date/time:** **Date of first assessment:**
REFERRER	Referred by (name and contact number):	

Continue information overleaf if necessary

HOSBIS Y CYMOEDD
Hospice of the Valleys

Patient Demographics

(Please apply patient label)

Date/Time	Continuation Sheet : Number	Sign/Print/Designation