

**BOLTON HOSPICE**

**REFERRAL FORM**

**PRIVATE AND CONFIDENTIAL**

PATIENTS FULL NAME: .....

D.O.B: ..... RBH No: ..... NHS No: .....

ADDRESS: .....

..... POST CODE: .....

TEL NO: ..... M/S/W/DIV/SEP: ..... OCCUPATION: .....

LOCATION IF DIFFERENT: .....

.....

REFERRED BY: (GP/CONSULTANT): .....

TEL NO: ..... DATE: .....

MAIN CARER: ..... RELATION: .....

ADDRESS: .....

..... TEL NO: .....

**DETAILS OF ILLNESS - PLEASE GIVE DATES**

Diagnosis: Primary: .....

Secondary: .....

Treatment: Operations: .....

Chemotherapy: .....

Radiotherapy: .....

CONSULTANTS: .....

PRESENT MEDICATIONS: .....

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AWARENESS OF DIAGNOSIS: PATIENT ..... CARERS .....

GP: .....

ADDRESS: .....

..... TEL NO: .....

MM NURSE: ..... DN: .....

SW: ..... OTHER: .....

**BOLTON HOSPICE, QUEENS PARK STREET,  
BOLTON, BL1 4QT**

**TELEPHONE: 01204 663066  
FAX: 01204 663060**

REASON FOR REFERRAL/MAIN PROBLEMS: .....  
.....  
.....

**REQUIREMENTS (Please Tick):**

ADMISSION FOR: SYMPTOM CONTROL  RESPITE CARE   
CONTINUING /TERMINAL CARE  REHABILITATION   
PSYCHOSOCIAL SUPPORT

DAY HOSPICE FOR: PAIN/SYMPTOM CONTROL   
PSYCHOSOCIAL SUPPORT

HOSPICE AT HOME: PAIN/SYMPTOM CONTROL   
PSYCHOSOCIAL SUPPORT   
RESPITE/AID FOR CARERS

OUT-PATIENT CONSULTATION

HOME MEDICAL ASSESSMENT

URGENCY: WITHIN 3 DAYS  10 DAYS  NOT URGENT

ANYTHING ELSE WE SHOULD KNOW: .....  
.....  
.....  
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TRANSPORT REQUIRED?: AMBULANCE YES /NO CAR YES/NO OWN YES/NO

Is it in order for the patient/family to be contacted from the Hospice: YES/NO

Is it in order for the Hospice to contact other care agencies, if appropriate? YES/NO

DOCTORS SIGNATURE: ..... DATE: .....

**FOR HOSPICE USE ONLY:**

ACTION:

SIGNATURE: ..... DATE: .....