**Send Referral to:** Bolhos.boltonhospice@nhs.net

**PLEASE ENSURE THIS FORM IS COMPLETED AS FULLY AS POSSIBLE TO AVOID DELAYS**

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| **PATIENT DETAILS** |
| **Name** |  | **Address** |  |
| **Gender** |  |
| **DOB** |  |
| **NHS No.** |  | **Tel** |  |
| **Hospital No.** |  | **Email Address** |  |
| **Ethnicity** |  | **Marital Status** |  |
| **Religion** |  | **Occupation** |  |
| **1st Language** |  | **Communication Difficulties?** |  |

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| **Service Requirements** |
| **Admission to In-Patient Unit** | **WBH - Day Services** | **Hospice @ Home** | **WBH - Outpatient Consultation** |  |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |  |
| **Covid-19 Information** |
| This patient is **suspected** of having Covid-19 | Y [ ]  / N [ ]  |
| This patient has tested **positive** for Covid-19  | Y [ ]  / N [ ]  |
| Date of swabs confirming diagnosis  | Click here to enter a date. |
| **Does the patient have an active infectious status, e.g. MRSA, CDiff?** |
| Y [ ]  / N [ ]  | If Yes, specify details below: |
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| **GP DETAILS** |
| **Registered GP** |  | **Surgery** |  |
| **Tel No.** |  |
| **Fax No.** |  |
| **Email** |  |

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| **Next of Kin / Patient Representative** | **Main Carer (if different)** |
| **Name** |  | **Name** |  |
| **Relationship** |  | **Relationship** |  |
| **Address** |  | **Address** |  |
| **Tel No.** |  | **Tel No.** |  |
| **Mob No.** |  | **Mob No.** |  |

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| **District Nurse** | **Macmillan** | **Social Worker** |
| **Name** |  | **Name** |  | **Name** |  |
| **Based at** |  | **Based at** |  | **Based at** |  |
| **Tel No.** |  | **Tel No.** |  | **Tel No.** |  |

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| **Consultants** |
| **1.** |  | **Hospital** |  |
| **2.** |  | **Hospital** |  |

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| **1. Diagnosis/extent of disease:**  |
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| **2. Past Treatments :** |
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| **3. Current Treatment Plans if any:** |
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| **4. Why do you want your patient to be seen at Bolton Hospice? (current symptoms/issues/concerns):** |
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| **5. Advance Care Planning in place/any/preferences of future care:** |
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| **6. DNACPR** |
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| **Please include any significant past medical history:**  |
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| **Please enclose a summary of current medications:** |
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| **Insight** |
| **Has the patient consented to this referral?** | Y [ ]  / N [ ]  | **Does the patient discuss the illness freely?** | Y [ ]  / N [ ]  |
| **Has the patient been told their diagnosis?** | Y [ ]  / N [ ]  | **Is the carer aware of the patient’s diagnosis?** | Y [ ]  / N [ ]  |

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| **Patient location if not at home** |
| **Address** |  |
| **Contact No.** |  |

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| **Has this patient got confirmed metastatic spinal cord compression?** |
| Y [ ]  / N [ ]  | If Yes, please complete the Metastatic Spinal Cord Compression Assessment at the end of this referral  |

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| **IF THE REFERRAL IS URGENT, PLEASE CONTACT THE HOSPICE BY PHONE TO DISCUSS THE PATIENT’S NEEDS ON 01204 663 066** |

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| **Referrer Details** |
| **Name** |  | **Signature** *(if printed)* |  |
| **Job Title** |  | **Contact No.** |  |
| **Base** |  | **Date**  |  |

**Upon completion, email this referral to:** **Bolhos.boltonhospice@nhs.net**

**Please ensure patients are aware that information will be held in accordance with the Data Protection Act**

| **For Hospice Use** |
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| Received by |  |
| Date Received | Click here to enter a date. | Date of first contact | Click here to enter a date. |
| Outcome |
|  |

**Bolton Hospice**

**Queens Park Street**

**Bolton**

**BL1 4QT**

**T:** 01204 663066

**F:** 01204 663060

**See our website** [www.boltonhospice.org.uk](http://www.boltonhospice.org.uk)

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| Name: D.O.B: NHS number: ………………… |
| Metastatic Spinal Cord Compression Assessment**On completion please e-mail to: BOLHOS.BoltonHospice@nhs.net** |
| **Diagnosis:****Prognosis:** |
| **Scan/ x-ray summaries:****Damage to vertebrae:****Level of compression:** |
| **Spinal Stability:****Bracing – when and how to wear:** |
| **Treatment had or planned:****Steroid regime:** |
| **What has patient been told: ( MSCC leaflet from Christie given?)****Baseline function at time of diagnosis:** |
| **Name:****Signature:** | **Designation:****Date: Time:** |

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| * **Pain |--------------------------------------|**

 0 10* **Emotional State / Psychological issues**
* **Therapy interventions to date**

**Physical Assessment: to include muscle power, dermatomes, flat bed rest details, proprioception, muscle tone, co-ordination.**  | * **Sleeping**
* **Elimination – bladder & bowel function**

**Awareness****Preferences**   bodychart |
| **Name:****Signature:** | **Designation:****Date: Time:** |