**Send Referral to:** [Bolhos.boltonhospice@nhs.net](mailto:Bolhos.boltonhospice@nhs.net)

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 :** |
|  |
|  |
| **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):** |
|  |
|  |
| **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**](mailto:Bolhos.boltonhospice@nhs.net)

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

| **For Hospice Use** | | | |
| --- | --- | --- | --- |
| 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)

|  |  |
| --- | --- |
| 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:** |