



# TRINITY

Palliative Care Services

Low Moor Road, Bispham, Blackpool FY2 0BG  
Tel: (01253) 595552 Fax: (01253) 595654

## PATIENT REFERRAL FORM FOR SPECIALIST PALLIATIVE CARE

ALL BOXES TO BE COMPLETED

SURNAME:		TITLE:	
1 <sup>ST</sup> FORENAME:	2 <sup>ND</sup> FORENAME:	KNOWN AS	
DOB:	MARITAL STATUS:	NHS NO:	
HOME ADDRESS:		POST CODE:	
		TEL NO:	
LOCATION OF PATIENT:		POST CODE:	
		TEL NO:	
LANGUAGE:		OCCUPATION:	
REFERRAL DATE:		IS PATIENT AWARE OF REFERRAL? Yes <input type="checkbox"/> No <input type="checkbox"/>	
GP's NAME:		CONSULTANT'S NAME:	
NAME OF REFERRING DOCTOR:		HOSPITAL NUMBER:	
PRIMARY SITE:		SITE OF SPREAD:	
DATE DIAGNOSED:			
DATE REFERRED TO DISTRICT NURSE:			
IS PATIENT AWARE OF DIAGNOSIS? Yes <input type="checkbox"/> No <input type="checkbox"/>		IS PATIENT AWARE OF PROGNOSIS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
IS CARER AWARE OF DIAGNOSIS? Yes <input type="checkbox"/> No <input type="checkbox"/>		IS CARER AWARE OF PROGNOSIS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
WHAT OTHER INFORMATION HAS BEEN GIVEN TO PATIENT/FAMILY:			

REQUEST FOR <b>ASSESSMENT</b> BY:-	
SPECIALIST COMMUNITY TEAM:	<input type="checkbox"/>
<b>OR</b>	
SPECIALIST HOSPITAL TEAM:	<input type="checkbox"/>
<b>REASON, PLEASE INDICATE:-</b>	
1. PAIN MANAGEMENT:	(Sites and Severity) <input type="checkbox"/>
	<input type="text"/>
2. SYMPTOM MANAGEMENT:	(Specify which) <input type="checkbox"/>
	<input type="text"/>
3. PSYCHOLOGICAL/EMOTIONAL PROBLEMS:	(Please specify) <input type="checkbox"/>
	<input type="text"/>
4. TERMINAL CARE:	<input type="checkbox"/>
<b>ADMISSION:-</b>	
1. ADMISSION TO TRINITY AS SOON AS POSSIBLE:	<input type="checkbox"/>
2. ADMISSION NOT REQUIRED:	<input type="checkbox"/>

<b>REFERRAL</b> FOR:-	
DAY THERAPY UNIT:	<input type="checkbox"/>
<b>REASONS FOR DAY THERAPY:-</b>	
1. SYMPTOM RELIEF:	<input type="checkbox"/>
2. EMOTIONAL SUPPORT:	<input type="checkbox"/>
3. REHABILITATION:	<input type="checkbox"/>
4. ANXIETY/STRESS MANAGEMENT:	<input type="checkbox"/>
5. REDUCE DEPRESSION:	<input type="checkbox"/>
6. REDUCE ISOLATION:	<input type="checkbox"/>
7. RELIEF OF CARER:	<input type="checkbox"/>



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HOW WAS DIAGNOSIS CONFIRMED example; Biopsy, Xray, Scan:
RELEVANT SURGERY - including operative findings and histology, Date and name of Surgeon:
HAS THE PATIENT UNDERGONE RADIOTHERAPY:- give details:
HAS THE PATIENT UNDERGONE CHEMOTHERAPY:- give details:
DOES THE PATIENT HAVE ANY UNDERLYING, LONG-STANDING PSYCHIATRIC/EMOTIONAL PROBLEMS:
ANY CO-EXISTING MEDICAL CONDITIONS:
SOCIAL CIRCUMSTANCES (CARER/DEPENDANTS):
CURRENT MEDICATION:
RELEVANT MEDICATION THAT HAS PREVIOUSLY NOT BEEN OF BENEFIT:

SIGNATURE OF REFERRING GP OR CONSULTANT:	DATE:

Please complete all boxes, as this information is required for the cancer unit 'Minimum data Set'. It is also very important for the Palliative Care Team in establishing a relationship with your patient. They expect us to have this information when we first meet them. Thank you.