



Confidential Referral Form

Beaumont House Community Hospice
32 London Road, Newark, Nottinghamshire. NG24 1TW
Tel: 01636 610 556 (24 hours) Fax: 01636 613262

Email: referral@beaumonthouse.co.uk Web: www.beaumonthouse.co.uk

Office use	
Reg. Number	Date assessed
Date referred	Action by
GP Coding Colour	If home visit, date
GSF Needs Based Coding Sticker	Assessed by
Long Term Conditions Patient?	Re-referral date
Date of any sticker change	

Patient details:

Title First Names..... Surname.....

Preferred name.....

Address.....

Town County..... Postcode.....

Telephone..... Mobile telephone.....

NHS No..... D.O.B..... Age.....

Occupation.....

Marital Status..... Gender.....

Ethnicity..... Religion/spiritual needs.....

Any immediate cultural/religious requirements.....

Name of preferred faith representative.....

English speaking? YES / NO Main language.....

Interpreter's details.....

Any other communication needs?

Has the patient full capacity? YES NO

Patient information

Diagnosis (& histology).....

Metastases..... Date of diagnosis.....

Estimated prognosis: days weeks 1-3 months 3-6 months 6months +

Mobility: Independent needs assisting mostly bedbound Paraplegic

Previous falls prior to admission- risk identified? YES NO

MRSA status (include dates).....
Any other known infections (include dates).....

Is the patient on prescribed oxygen – YES / NO flow rate.....

Beaumont House does not have piped oxygen installed and can only supply concentrated oxygen. We require 48 hours notice if required and a completed Home Oxygen Order Form (HOOF) form.

Home Oxygen Order Form (HOOF) attached? YES NO

Known Allergies

Diabetic YES NO

If YES - controlled by Medication Insulin

Any special nursing needs.....

Is the patient aware of this referral? YES NO

Is the patient aware of their diagnosis? YES NO

Has the patient consented to share information with the PHCT? YES NO

Has prognosis been discussed with the patient? YES NO

by whom and date

Has CPR been discussed with the patient/carer? YES NO

by whom and date

ADRT YES NO (if yes please provide copy)

EMAS YES NO (if yes please provide copy)

ACP YES NO

Preferred place of care (PPC).....

Preferred place of death (PPD).....

Current patient location (please tick)

HOME

Does the patient live alone YES NO

Are you aware of any risk to staff visiting this patient in their home? YES NO

If yes, please give any relevant details.....

HOSPITAL

Hospital..... Ward.....

Telephone..... Name of Key Worker

Is the patient fit for travel? YES NO

Reasons for referral (please tick)

- | | | |
|---|--|---|
| <input type="checkbox"/> In-patient/respite | <input type="checkbox"/> Day care | <input type="checkbox"/> Community team |
| <input type="checkbox"/> Complementary therapies | <input type="checkbox"/> Welfare Benefits advice | <input type="checkbox"/> Equipment loan |
| <input type="checkbox"/> Bereavement support – (for families already known to BH) | | |
| <input type="checkbox"/> General support | <input type="checkbox"/> Symptom control | <input type="checkbox"/> End of life care |
| <input type="checkbox"/> Psychological support | | |

Contact details**GP name**.....

Surgery.....

Postcode.....

TelephoneFax.....

Is GP aware of referral? YES NOIs patient on the GP palliative care register? YES NO**Further hospital details**

Consultant most recently in charge.....

Is the consultant aware of this referral? YES NOHospital/clinic letters requested YES NO**CNS team (tumour site specific)**

Name of contact.....

TelephoneFax.....

Is the hospital PC team aware of referral? YES NO**Community Macmillan Clinical Nurse Specialist\Long Term Condition CNS**

Name of contact..... Based at:

Telephone..... Fax.....

District Nurse (essential for community referrals)

Name of contact..... Based at:

Telephone..... Fax.....

Next of kin (if known)
1st contact

Title First Names..... Surname.....
Address.....
Town County..... Postcode.....
Telephone day..... Telephone night.....
Mobile.....
Relationship to patient.....

2nd contact (if known)

Title First Names..... Surname.....
Address.....
Town County..... Postcode.....
Telephone day..... Telephone night.....
Mobile.....
Relationship to patient.....

Lasting Power of Attorney

(Person legally appointed by the patient to make healthcare decisions on their behalf (if applicable))

Title First Names..... Surname.....
Address.....
Town County..... Postcode.....
Telephone..... Mobile.....
Date appointed.....

Main carer (if applicable)

Title First Names..... Surname.....
Address.....
Town County..... Postcode.....
Telephone..... Mobile.....

Benefits

DS 1500 applied for? YES NO if YES by whom.....

Other benefits applied for eg. DLA, Carers Allowance, Attendance Allowance, MacMillan Grant

Please specify.....

.....

Date applied for..... by whom.....

Has a Continuing Care Assessment been completed YES NO

If yes, funded by: Social Services /Joint funding

Date when fast tracked.....

Name of current provider.....

Contact telephone number.....

Fast track applied for by (PLEASE TICK)

- DN MN LTC Matron CNS
- GP Consultant Hospital team

Details of current care package.....

.....

Any other key professionals involved (please tick)

- OT SW Physio
- Dietician Colostomy nurse Pain team

Other – (please specify).....

Name of contact..... Based at:

Telephone..... Fax.....

Please turn over

Anticipatory Medication

Please note: In line with Gold Standard Framework best practise and Nottinghamshire PCT policy guidelines, if the Patient is End of Life and is being admitted for possible terminal care, please write up anticipatory medication **prior** to admission.

Anticipatory Medication details:

Drug name & strength	Dose	Frequency	Route

Has this medication been prescribed? YES NO

Referred by

Title..... First name..... Last name.....

Date of referral..... Based at

Telephone Number.....

Referral actioned by..... Discussed at planning meeting YES NO

Please read this:

It is essential that you also fax or attach a photocopy of a recent medical summary (which describes diagnosis, histology, treatments, medication changes) **AND** recent clinic letters and blood results.

Thank you for all the time you have taken to convey this information - it greatly improves the patients' experience of referral.

Please feel free to call us if it would help on 01636 610556 and ask to speak to the Duty Manager.