

Community Palliative Care Team
 (Referral Criteria: [click here](#))
Urgent **Non Urgent**

St Leonard's Hospice Inpatient Unit
Date of referral:

Patient name:	NHS Number:	
Address:	DOB: Phone no:	
NOK:	Relationship: Contact details:	
Consent agreed for referral? Y <input type="checkbox"/> N <input type="checkbox"/>		
Please note that referrals will not be accepted unless the patient or main carer has consented to the referral		
DIAGNOSIS :		
Karnofsky Score:		
Phase of Illness:- Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Dying <input type="checkbox"/>		
Is Patient aware of diagnosis: Y <input type="checkbox"/> N <input type="checkbox"/> Is Patient aware of prognosis: Y <input type="checkbox"/> N <input type="checkbox"/>		
Current/Planned Treatments:		
MAIN CONCERNS - REASON FOR REFERRAL		
Pain <input type="checkbox"/>	Symptom control <input type="checkbox"/>	Last days of life care <input type="checkbox"/>
Social/financial <input type="checkbox"/>	Psychological Care <input type="checkbox"/>	ACP Discussion <input type="checkbox"/>
Please outline the main Physical/Psychological/Social/ Spiritual Issues:		
DNACPR in place? Yes / No	Anticipatory Drugs in place Yes / No	
Name of referrer:	Date of referral:	
Position:	Contact no:	

Please email completed form to: SLEHO.spcreferrals@nhs.net

FOR URGENT REFERRALS PLEASE RING 01904 777770