

COTSWOLD CARE HOSPICE
Hospice at Home Referral Form

Burleigh Lane, Minchinhampton, GL5 2PQ
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(Referral forms available to download from: <http://www.cotswoldcare.org.uk>)

Essential Patient Details**PIN No (office use only):**

Title:	Surname:	First name:	Gender:
DoB:	Marital status: M / W / D / S / Partner	Ethnicity:	Religion:
Address:		Is the patient registered disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Postcode:		Tel:	
		Mobile:	

Directions to house / Parking instructions:
(NB Hospice at Home may visit at night)

Map Ref (Office Use): _____

Key Safe number and location of key safe:

	Y	N	Details
Do not resuscitate agreed	<input type="checkbox"/>	<input type="checkbox"/>	
Mental capacity issues	<input type="checkbox"/>	<input type="checkbox"/>	
Pets in house	<input type="checkbox"/>	<input type="checkbox"/>	
Smokers in house	<input type="checkbox"/>	<input type="checkbox"/>	
Any other risks identified	<input type="checkbox"/>	<input type="checkbox"/>	

Main carer / contact

Name:	Relationship to patient:
Address:	Tel:
Postcode:	Mobile:

Other carer (optional)

Name:	Relationship to patient:
Address:	Tel:
Postcode:	Mobile:

Professional Contact Details

GP:	Base / Address:	Tel:
DN:	Base / Address:	Tel:
Other:	Base / Address:	Tel:

Patient Name:	Patient DOB:
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Medical Details

Diagnosis:	Prognosis:	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks
Date of Diagnosis:	Is the patient's pref. to die at home?	<input type="checkbox"/> Months	<input type="checkbox"/> Years
		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Coroner to be informed: e.g. Mesothelioma Yes No Don't Know

Liverpool Care Pathway (LCP) commenced: Yes No Don't Know

Medication in house:	Details:
<input type="checkbox"/> Oral <input type="checkbox"/> Buccal	
<input type="checkbox"/> Injectable / syringe driver	
<input type="checkbox"/> Rectal <input type="checkbox"/> Other	

Care Details (Tick box and give details if necessary)

Equipment:	4-way <input type="checkbox"/> profiling bed <input type="checkbox"/> Slide sheets	<input type="checkbox"/> Hoist	<input type="checkbox"/> Other	Details:
Continence:	<input type="checkbox"/> Continent <input type="checkbox"/> Pads	<input type="checkbox"/> Suction	<input type="checkbox"/> Commode / Bed pan <input type="checkbox"/> Catheter <input type="checkbox"/> Stoma	Details:
Nutrition:	<input type="checkbox"/> Normal diet <input type="checkbox"/> Anorexic	<input type="checkbox"/> Fluids only	<input type="checkbox"/> Other <input type="checkbox"/> Unable to swallow <input type="checkbox"/> Peg	Details:
Mobility:	<input type="checkbox"/> Unaided <input type="checkbox"/> Bed-bound	<input type="checkbox"/> With aid	<input type="checkbox"/> Hoist <input type="checkbox"/> Other	Details:
Care Agencies involved:	<input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Other		Details:

Any other relevant information (e.g. family details, psychosocial, spiritual issues, carers needs)
PLEASE COMPLETE:

Referrers name:	Base and/or Address:	
Job title:	Contact Number:	Date of Referral:

