

**COTSWOLD CARE HOSPICE**  
Care Services Referral Form



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Tel: 01453 886868 Fax: 01453 885282

(Referral forms available to download from: <http://www.cotswoldcare.org.uk>)

Essential Client Details		PIN No (office use only):	
Surname:	Gender:	Client consent to referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>
First Name:	DOB:	Marital Status: M / W/ D/ S / Partner	
Address:		Does the client live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Postcode:		Is the client registered disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Tel:		Religion:	
Mobile:		Ethnicity:	
		Occupation:	
<b>Reasons for Referral (please specify)</b>		<b>Name of referrer (please print)</b>	
Day Therapy <input type="checkbox"/>		_____	
Counselling <input type="checkbox"/>		Job Title: _____	
Complementary Therapies <input type="checkbox"/>		GP/Surgery or Hospital:	
Art for Health <input type="checkbox"/>		Contact No:	
Physiotherapy <input type="checkbox"/>		Date:	
<b>Client Next of Kin &amp; Relationship</b>		<b>Main Carer (if different):</b>	
Name:		Name:	
Address:		Address:	
Postcode:	Tel:	Postcode:	Tel:
<b>Is GP aware of referral</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>District Nurse Name:</b>	
GP Name:		Based at:	
Surgery:		Tel:	
Postcode:			
Tel:		Fax:	
<b>CNS – Name:</b>		<b>Consultant Name/s</b>	
Address:		Address:	
Postcode:		Postcode:	
Tel:		Tel:	
Fax:		Fax:	
<b>Does the client have a living will or advanced directive?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
<b>Does the client have any mental capacity issues?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
<b>NB: PLEASE ATTACH A PHOTOCOPY OF RECENT CLINICAL CORRESPONDENCE, IN SUPPORT OF THIS REFERRAL AND ENSURE THAT CLIENTS ARE AWARE INFO WILL BE HELD ON COMPUTER ACCORDING TO THE DATA PROTECTION ACT.</b>			

<b>Client Name:</b>	<b>Client DOB:</b>
<b>DISEASE STATUS</b> Diagnosis:  Date of diagnosis:	<b>Site of metastases (if malignancy) or related symptoms:</b>
<b>Past/Current Treatments:</b>	
<b>Disease Stage:</b> Early <input type="checkbox"/> Advanced <input type="checkbox"/> <b>Management:</b> Curative <input type="checkbox"/> Non-Curative <input type="checkbox"/> <b>Prognosis:</b>	
<b>Is client aware of diagnosis/prognosis?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
<b>Relevant Past Medical and Psychiatric History</b>	<b>Current Medication: (name, dose, frequency, or send an up-to-date computer print out)</b>
<b>Known Drug Sensitivities/Allergies</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  Details:	<b>Infection Status:</b> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Known <input type="checkbox"/> Details:
<b>Main problems and symptoms (including mobility, nutritional requirements, any concerns of the client or family/carers, or other information that would support this referral).</b>	