**Wellbeing Centre Referral Form**

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| REFERRAL CRITERIA | | | | | | | | | | | |
| Able to attend Teesside Hospice and participate in group/individual activities (Mandatory)  Does the person meet criteria? Please tick all that apply  Diagnosed with life limiting illness           Medically stable  Would benefit from symptom management/social interaction/holistic support  Able to participate in group/individual activities  Carer support needs identified | | | | | | | | | | | |
| Section 1: PATIENT DETAILS | | | | | | | | | | | |
| Full name |  | | | | | | | | | | |
| Date of birth |  | | | | | | Age: | | | | |
| NHS Number |  | | | | | | | | | | |
| Address |  | | | | | | | | | | |
| Postcode |  | | | | | | Email address | | | | |
| Telephone Number |  | | | | | | | | | | |
| Primary Language |  | | | | | | | | | | |
| Ethnic group | Choose an item. | | | | | | Interpreter Required Choose an item. | | | | |
| GP Practice |  | | | | | | GP telephone number | | | | |
| Primary Diagnosis |  | | | | | | | | | | |
| Current treatment: |  | | | | | | | | | | |
| Consultant : |  | | | | | | | | | | |
| Other relevant PMH |  | | | | | | | | | | |
| Carer/NOK details |  | | | | | | Telephone number | | | | |
| Section 2: REFERRER DETAILS | | | | | | | | | | | |
| Referrer name |  | | | | | | | | | | |
| Job title |  | | | | | Organisation | | |  | | |
| Consent for referral | Choose an item. | | | | | Other health care professionals informed of referral Choose an item. | | | | | |
| Other professionals involved if known please give contact details | Choose an item. | | | | | | | | | | |
| Referral Urgency | Choose an item. | | | | | | | | | | |
| If urgent please state reason/please ring to discuss further: | | | | | | | | | | | |
| Section 3: REASON FOR REFERAL | | | | | | | | | | | |
| Symptom management    Please state Choose an item. | | | | | | | | | | | |
| Breathlessness management  Fatigue management  Emotional/psychological support  Social Isolation  Carer support | | | | | | | | Advance care planning   Social worker/welfare advice  Dementia Support   Introduction to Hospice services  Access to Complementary therapy | | | |
| Additional information/Current problems. | | | | | | | | | | | |
| Current symptoms other please state |  | | | | | | | | | | |
| **Current medication list** | | | | | | | | | | | |
| Mobility including aids | | Independent | | | Needs support | | | | | Dependent | |
| Toileting | |  | | |  | | | | |  | |
| Nutrition | |  | | |  | | | | |  | |
| Personal Care | |  | | |  | | | | |  | |
| Cognitive Impairment | | Mild | | | Moderate | | | | | Severe | N/A |
| Depression/Anxiety | |  | | |  | | | | |  |  |
| Risk of Social Isolation | |  | | |  | | | | |  |  |
| H/O behavioural concerns | |  | | |  | | | | |  |  |
| Does patient have capacity? | | | Choose an item. | | | | | | | | |
| Risks: | | | Falls   H/O drug/alcohol dependence  Choose an item. | | | | | | | | |
| Advance Care Planning:  Patients preferred place of care/death  Please state if discussed/ completed | | | | Choose an item.  Choose an item.  Choose an item. | | | | | | | |
| Additional information: Oxygen therapy               Wounds/pressure damage   Please provide information: | | | | | | | | | | | |
| **All patients will be offered an appointment for initial assessment within 28 days of receiving referral**  **At initial assessment we will formulate patient goals and signpost to most appropriate Treatment/Group/1:1/Workshop**  **Please note all sessions are time limited** | | | | | | | | | | | |

*Thank you for completing this form* ***Please complete all sections of the form as Incomplete forms may result in referral being delayed or rejected.***

***Please email this form to:*** [***stees.teessidehospice.cas@nhs.net***](mailto:stees.teessidehospice.cas@nhs.net) ***Tel: 01642 811072***