**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   |   |
| Date of referral  |  | Contact No: |  |
| 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*** ***Tel: 01642 811072***