PLEASE RETURN TO: -
Turner Centre, St Michael's Hospice (North Hampshire)
Basil de Ferranti House, Aldermaston Road, Basingstoke, Hampshire RG24 9NB Tel: 01256 848870 Fax: 01256 848871

Complementary Therapy Services Referral Form

Main reason for referral:

PATIENT DETAILS.

Surname…… DOB……..

First name……. Male/Female

Known as …… Lives alone **YES/NO**

Address …… Occupation……..

…… Language …….

…… Patient aware of referral **YES/NO**

Telephone No …….

Patients preferred treatment site *(please tick)*: Hospice ☐ Odiham Cottage Hospital ☐ Home ☐

NEXT OF KIN / MAIN CARER DETAILS (if different)

Surname ……

First name ……

Relationship ……..

Address……

……

Telephone No ……

GENERAL PRACTITIONER

Name ……

Surgery……..

Telephone No ……..

GP aware of referral **YES/NO**

REFERRER DETAILS

Name …… Telephone No ……..

Title …… Fax No ……..

Department ……..

OTHER PROFESSIONALS INVOLVED

NAME	**CONTACT DETAILS**
CONSULTANT……	……..
CONSULTANT……	……..
DISTRICT NURSE ……	……..
CNS ……	……..
OTHER ……	……..

DIAGNOSIS

PRESENT CONDITION AND PATIENT'S PERCEPTION OF DISEASE

DATE	TREATMENTS, (surgery, chemotherapy and radiotherapy) and DISEASE PROGRESSION

PAST MEDICAL HISTORY

CURRENT PROBLEMS ***(please tick as appropriate)***

BP High/Low	☐	**Osteoporosis**	☐	**Confidence**	☐	**Epilepsy/fits**	☐
Pain	☐	**Bowel problems**	☐	**Cough**	☐	**Anxiety/stress**	☐
Nausea/vomiting	☐	**Fatigue**	☐	**Dyspnoea**	☐	**Depression**	☐
Lymphoedema	☐	**Mood/motivation**	☐	**Insomnia**	☐	**Confusion**	☐
DVT/FE	☐	**Mobility issues**	☐	**Weakness**	☐	**Diabetes**	☐
Poor body image	☐	**Communication issues**	☐	**Adjustment to disease**	☐	**Any infection**	☐

Details (please specify):

ALLERGIES

Any known allergies **YES/NO**

If yes, please specify:

Signature of Referrer: **Date:**