

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 | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Confidence | <input type="checkbox"/> | Epilepsy/fits | <input type="checkbox"/> |
| Pain | <input type="checkbox"/> | Bowel problems | <input type="checkbox"/> | Cough | <input type="checkbox"/> | Anxiety/stress | <input type="checkbox"/> |
| Nausea/vomiting | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | Dyspnoea | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Lymphoedema | <input type="checkbox"/> | Mood/motivation | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | Confusion | <input type="checkbox"/> |
| DVT/FE | <input type="checkbox"/> | Mobility issues | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Poor body image | <input type="checkbox"/> | Communication issues | <input type="checkbox"/> | Adjustment to disease | <input type="checkbox"/> | Any infection | <input type="checkbox"/> |

Details *(please specify)*:

ALLERGIES

Any known allergies **YES/NO**

If yes, please specify:

Signature of Referrer:

Date: