Hampshire Hospitals
NHS Foundation Trust

Hampshire Hospitals Palliative Care Service Referral Form

Please email to: palliativecare@hhft.nhs.uk or St Michael's Hospice: smhadmin@hhft.nhs.uk
If you would like to discuss further, please phone relevant part of service.

Community Palliative Care Team – Tel: 01256 314729

St Michael's Hospice – Tel: 01256 844744

PATIENT DETAILS

Surname: ..... DOB: .....
First Name: ..... Known as: .....
Address: .....
.....
Telephone No: ..... Mobile No: .....
Sex: Male / Female Lives alone: YES / NO Patient aware of referral: YES / NO

NEXT OF KIN / MAIN CARER DETAILS (if different)

Surname: .....
First Name: .....
Relationship: .....
Address: .....
.....
Tel No: .....Mobile No: .....

GENERAL PRACTITIONER

Name Dr: .....
Surgery: .....
Telephone No: .....
GP aware of referral: YES / NO

CURRENT LOCATION OF PATIENT (please tick)

Home ☐ Other ☐ .....

REFERRER DETAILS

Name: .....
Title: .....
Department: .....
Telephone No: .....

PERCEPTION OF DISEASE / PROGNOSIS

Patient: .....
.....
Family: .....
.....

Referrals must include:

Detailed reason for referral e.g. Symptom control / Psychological Support / Ethical decision making / Advance care planning

- Working diagnosis

PLEASE TICK IDEAL RESPONSE TIME

☐ **Urgent (Please discuss by phone – 01256 314729)** ☐ **Non-urgent**