|  |  |
| --- | --- |
| **ACCORD Hospice****Referral Form****Medical - In Confidence****Referrals cannot be accepted if information on this form is incomplete** | **Please email to:** **ggc.accordhospice@nhs.scot****Medical Secretaries****ACCORD Hospice****Morton Avenue****Paisley PA2 7BW****Tel: 0141 581 2026****Hospice** **Case Record No:**        |
| **Patient Information:** Name:      Address:             Post Code:      Ethnicity:       | DOB:      CHI No:       Marital Status: Patient’s Tel No:      Religion:        |
| **Main Carer / NOK Details:** Name:       Relationship to patient:      Address:             Tel No. Day:       Night:       | **Patient’s GP:**Name:       Address:             Post Code:      Tel No:       |
| **Diagnosis:**Primary:       Date of Diagnosis:       Site(s) of Secondaries:       | **Hospital Consultant(s):**Name:       Hospital:       Name:       Hospital:       |
| **Investigations & Treatment (please attach relevant correspondence):**      |
| **Past Medical History:**      |

|  |
| --- |
| **Patient informed of diagnosis: Yes** **[ ]  No** **[ ]  Patient aware of referral: Yes [ ]  No [ ]**  |
| **Service Required:** (please check appropriate boxes)Consultant Review - Outpatient Clinic [ ]  CNS Assessment [ ]  - Domiciliary Visit [ ]  (Clinical Nurse Specialist – Community)In-Patient Unit Admission [ ]  Day Therapy Unit [ ]  Bereavement Support [ ]  Physiotherapy [ ]  Lymphoedema Clinic [ ]  Patient & Family Support [ ]   **Reason for Referral:** Symptom Control [ ]  Respite Care [ ]  End of Life Care [ ]  **Patient Currently:** At Home [ ]  In Hospital:       Ward:      Care Home:       Tel No:       |
| **Current Medication:**      **Allergies:**       |
| **Please select score describing your patient using the following 0 – 4 guide:**  |
| **Pain**  | **Symptom (**specify)       | **Symptom** (specify)       |
| **Symptom (**specify)       | **Mobility** | **Family Anxiety**  |
| **Care Environment** | **Spiritual Distress** | **Please note, a low score does****not necessarily mean your****patient will not be a priority admission** **Adapted from STAS****(Support Team Assessment Schedule)** |
|  **Perceived level of urgency: E =** Emergency ( 24 - 48hrs )**Total Score:** (please circle as appropriate) **U =** Urgent ( within 1 week ) **N =** Non Urgent ( within 4 weeks ) |
| **Signature of Referrer:**       | **Designation:**       | **Date:**       |
| **Address:**       |