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| **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**](mailto: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:** | |

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| **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:** | | | | |