st oswald's hospice
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ST OSWALD'S HOSPICE FOCUS ON LIVING CENTRE REFERRAL FORM

Title	**Surname**		**First name**	**Preferred name**
DOB	**Age**	**Sex** Male ☐ Female ☐	**NHS Number**	**Date of Referral**
Address **Postcode**			**Telephone Number** **Ethnic Group** **Interpreter required** Yes ☐ No ☐	**Lives alone** Yes ☐ No ☐ **Religion**
NOK details / Main carer **Full name** **Address** **Telephone Number (mobile)** **Relationship**			**Referred by** **Designation** **Contact** **Consent agreed for referral** Yes ☐ No ☐ *please note referral will not be accepted if patient or main carer has not consented to referral	
Diagnosis Primary: Secondary: **Date** **Known to Social Services** Yes ☐ No ☐			**GP** **Address** **Telephone Number**	
Macmillan Nurse	Telephone Number		**District Nurse**	Telephone Number
Clinical Nurse Specialist	Telephone Number		**Consultant**	Telephone Number
Reason for referral:				
☐ Pain /Symptom management (please specify symptoms)	☐ Psychological/ Emotional support		☐ Spiritual support	☐ Social Support
			☐ Other (please specify)	

Please indicate which services person may be interested in attending (tick all that apply)			
☐ Carer support	☐ Breathlessness management	☐ Family support team / counselling	☐ Fatigue management (group session)
☐ Occupational Therapy	☐ Complementary therapies	☐ Physiotherapy	☐ Creative writing (group session)
☐ Social Worker	☐ Arts and Crafts	☐ Nursing support	☐ Relaxation therapies (group session)

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☐ Tripudio (group session)	☐ Acupuncture	☐ Positive Steps programme	☐ Day Hospice
☐ Restorative yoga (group session)	☐ Talking therapies	☐Psychology/ Wellbeing	

Advanced decisions/statements

EHCP Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
LPA Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐
DNACPR Discussed Yes ☐ No ☐	Completed Yes ☐ No ☐

Any other advanced decisions/statements completed or disclosed

Relevant medical history, including medication, allergies and any current nursing interventions

Any cognitive impairment and/or sensory impairment. If yes please provide relevant information

Can Mental Capacity be assumed? If No- what is the reason for needing to assess capacity

Any relevant information including the situation leading up to this referral

Additional information

☐ Assistance needed with medication?	☐ PEG	☐ Oxygen therapy	☐ Syringe Driver
☐ Wounds/pressure damage?	☐ Known infection?	☐ Seizure activity	

If yes to any of the above, or any other relevant information please comment below

Please complete and return referral form to: necne.referrals@nhs.net