Compton Hospice, Compton Road West
Compton, Wolverhampton. WV3 9DH
Telephone: 0845 2255 497
Fax: 01902 745232

COMPTON HOSPICE
REFERRAL FORM

PRIVATE & CONFIDENTIAL

Please fill in this form COMPLETELY and include copies of significant hospital letters. We normally contact the patient by telephone after receipt of all the necessary information. Please telephone if urgent action required or you wish to discuss a complex problem.
(Please ✓ where necessary)

1 PATIENT DETAILS:

Name: .....

Address: .....

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Post Code: .....

DOB: Telephone No: Mobile:

NHS No Does the patient live alone? YES ☐ NO ☐

Are they: ☐ Married ☐ Divorced ☐ Single ☐ Partner ☐ Widowed ☐ Separated

Name of carer/next of kin: Relationship to patient:

Address (if different from above):

Postcode: Telephone No: Mobile:

2 GP Information (Must be completed for all referrals)

GP Name

Practice Name

Telephone No

Address

Has the GP agreed to this referral? YES ☐ NO ☐

3 Hospital details

Hospital

Ward/OP

Hospital No.

Consultant

Discharge date if in-patient: / /

Discharge address/ tel.no:

4 Does the patient agree to hospice referral? YES ☐ NO ☐

Agreement is required unless there are exceptional circumstances. If you have ticked **NO** then please indicate why in Section 8 or telephone medical secretaries on 0845 2255497 with further information.

5 Other Agencies involved:
Specialist Nurse/Social Worker/District Nurse/Physiotherapist/O.T./Comp. Therapist/Lymphoedema/Dietician / SALT etc.

NAME:	ROLE:	LOCATION:	TEL. NO:

PATIENT'S NAME:

6 Information about diagnosis/prognosis/other medical conditions

Diagnosis:

Date of Diagnosis:

Current disease status and treatment aims:

Estimated prognosis:

Other significant medical conditions:

Patient and relatives' understanding of diagnosis/prognosis/ treatment:

Is the patient on the Gold Standards Framework Register? YES ☐ NO ☐ DON'T KNOW ☐

Is the patient on the: Supportive care pathway / End of life care pathway / Liverpool care pathway PATHWAY NOT KNOWN ☐

(please circle)

7 Reason for referral:
What are the current problems/needs of the patient/family? (Can include Physical/Social/Psychological/Spiritual issues)

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8 Other relevant information (including mobility/access/mental capacity issues/communication/translator needed/language):

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9 Referrer information

Name:

(Please print name)

Job Title:

Tel.No:

Signature of referrer

Date

Please remember to send copies of significant hospital letters/confirmation of diagnosis