Chief Executive
Sr Rita Dawson

Director of Medical Services
Prof. Marie Fallon

Medical Team
Professor John Welsh
Dr Barry Laird
Dr Colin Barrett
Dr Guy Haworth

REFERRAL FORM

ST MARGARET OF SCOTLAND HOSPICE

EAST BARNS STREET • CLYDEBANK • G81 1EG
TELEPHONE 0141 952 1141 • FAX 0141 951 4206
Email: office@smh.org.uk

REFERRAL FOR:

CONSULTANT LED OUTPATIENT CLINIC ☐

COMMUNITY PALLIATIVE CARE TEAM ☐
(The areas covered by this service are G3, G11, G12, G13, G14, G15, G60, G61, G62, G81 and parts of G20)

DAY REHABILITATION UNIT ☐

BEREAVEMENT SUPPORT ☐

IN-PATIENT ADMISSION

SYMPTOM CONTROL ☐ END OF LIFE CARE ☐ RESPITE CARE (FROM HOME ONLY) ☐

PATIENT DETAILS:

SURNAME: …….. FORENAME: …… CHI: ……

ADDRESS: …… TELEPHONE NUMBER: ……..

…….. POSTCODE: ……..

DATE OF BIRTH: …… MARTIAL STATUS: …… RELIGION: ……

NEXT OF KIN:

NAME: …… RELATIONSHIP: ……..

ADDRESS: …… TELEPHONE NUMBER: ……..

…….. POSTCODE: ……..

GENERAL PRACTITIONER:

NAME: ……

ADDRESS: …… TELEPHONE NUMBER: ……..

…….. POSTCODE: ……..

IF REFERRING FROM HOSPITAL:

CONSULTANT: …… HOSPITAL: …….. WARD: ……..

TELEPHONE NUMBER: …… IS GP AWARE OF REFERRAL: YES/NO

IS THE PATIENT:		DOES THE PATIENT HAVE:	
AWARE OF THE REFERRAL	YES/NO	A PACEMAKER	YES/NO
AWARE OF THE DIAGNOSIS	YES/NO	AN IMPLANT	YES/NO
AWARE OF THE PROGNOSIS	YES/NO	ANY ALLERGIES	YES/NO

DOES THE PATIENT HAVE ANY INFECTION WHICH WOULD REQUIRE A SINGLE ROOM YES/NO

DIAGNOSIS: …… DATE OF DIAGNOSIS: ……

KNOWN METASTASES: …… HISTOLOGY: ……

EXACT SITE OF PRIMARY TUMOUR: ……..

ESTIMATED PROGNOSIS: …… DAYS/WEEKS/MONTHS

HOSPITAL TREATMENT:

SURGICAL	CONSULTANT	HOSPITAL	DATE
……	……	……	……
……	……	……	……
……	……	……	……

MEDICAL/ONCOLOGICAL

……	……	……	……
……	……	……	……
……	……	……	……

OTHER RELEVANT MEDICAL HISTORY:

……

……

……

REASON FOR REFERRAL:

The following are some areas for referring a patient for specialist palliative care. Please circle the severity of the following from 1 to 4; 1 being mild and 4 being overwhelming.

AGITATION	1	2	3	4	FAMILY DISTRESS	1	2	3	4			
NAUSEA	1	2	3	4	SPIRITUAL/EXISTENTIAL DISTRESS	1	2	3	4			
VOMITING	1	2	3	4	DISTRESS DUE TO CARE ENVIRONMENT	1	2	3	4			
DYSPNOEA	1	2	3	4	END OF LIFE (LAST 48-72 HOURS OF LIFE)	YES/NO						
CONSTIPATION	1	2	3	4	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
							Mild			Moderate				Severe			
PATIENT DISTRESS	1	2	3	4	OTHER – PLEASE SPECIFY												
DEPRESSION	1	2	3	4													

MEDICATIONS:

……	……
……	……
……	……
……	……
……	……
……	……

FORM COMPLETED BY: …… **ADDRESS:** ……...

…… **TELEPHONE NUMBER:** ……...

SIGNATURE: …… **DESIGNATION:** …….. **DATE:** ……..

When a patient is being transferred between hospitals, care records should always accompany the patient. When the patient is admitted from home, photocopies of key letters and discharge summaries should accompany the patient.

PLEASE RETURN THIS FORM TO SISTER RITA OR DOCTOR ON DUTY