LES BOURGS HOSPICE - REFERRAL FORM

TEL NO. 251111 FAX NO. 251027 EMAIL: nurses@lesbourgs.com

NAME		**DOB**			
ADDRESS					
		POSTCODE			
NEXT OF KIN (name and contact number)				**NOK INFORMED?**	
GP		**SURGERY**		**GP AWARE?**	
PATIENT LOCATION		**RESUS STATUS**			
DIAGNOSIS **PATIENT AWARE?**	**YES/NO** (PLEASE CIRCLE)				
WHY HOSPICE CARE?			**REASON FOR REFERRAL** (PLEASE CIRCLE)	**COMPLEX RESPITE,** **SYMPTOM CONTROL,** **END OF LIFE CARE**	
NAP CERTIFICATE?	**YES/NO/ AWAITING**	**ARE FAMILY AND PATIENT AWARE OF POSSIBLE TOP UP CHARGES?**			
CURRENT MEDICATIONS **ALLERGIES**					
SPECIAL DIETARY REQUIREMENTS			**SMOKING STATUS**		
MDT INVOLVED (PLEASE PROVIDE NAMES OF ANY SERVICES AND SPECIALIST DOCTORS OR NURSES INVOLVED.)		**EQUIPMENT NEEDS** (IE OXYGEN, ALTERNATING PRESSURE MATTRESS)			
REFERRED BY		**DATE**			

(INTERNAL USE ONLY)			
DATE REFERRAL RECEIVED		ON CALL INFORMED? (DATE AND TIME)	
NAME		SIGNATURE	
DATE OF ADMISSION OR REASON FOR NOT ADMITTING			