Cornwall Hospice Care
Caring for our community
Neighbourhood Hubs
Registered Charity No. 1113140

Referral to Cornwall Hospice Care Neighbourhood Hubs

Please complete as much as possible and email this form to: referrals@cornwallhospice.co.uk
or Post to: St Julia's Hospice, Foundry Hill, Hayle, TR27 4HW
or Phone: 01726 829874

Use this form if the person referred:
- has a diagnosis of a terminal condition OR is a carer of a person diagnosed with a terminal condition.
- currently has complex unmet needs.
- is aware of AND consents to this referral.

Date:	Time:
Details of person being referred **Patient** ☐ **Carer** ☐	
Surname:	Title:
First name:	Male ☐ Female ☐
Likes to be called:	Ethnicity:
Date of birth:	NHS number:
Address:	
Post code:	
Telephone:	Mobile:
The person lives alone: Yes ☐ No ☐ with whom?	
Any communication difficulties (please detail)	
Best method/person for initial contact?	
The person is aware of and has consented to this referral: Yes ☐ No ☐ Does not have capacity ☐	
Is the person already known to this service? Yes ☐ No ☐ Don't know ☐	
Reason(s) for referral (tick all that apply and give further details if possible)	
☐Symptom control advice ☐Emotional/psychological support ☐Advance Care Planning ☐Rehabilitation ☐Mobility ☐Activities of Daily Living ☐Social/financial support ☐Lymphoedema	
Significant other: (If patient: Next of Kin / Main Carer - If carer: patient details)	
Title:	Full name:
Address:	
Telephone:	Mobile:
Relationship to person referred:	

Patient Medical / Social Information	
Diagnosis including date(s) and stage of disease:	
Current symptoms:	
Current medication & treatments:	
Relevant past medical history:	
Social circumstances / care package / other relevant information:	
Are there any risks visiting this person at home? (i.e infection, lone working, access, pets…)	
TEP form completed or considered?	
Professionals Already Involved	
GP name:	GP telephone number:
GP address:	
GP aware of referral? YES ☐ NO ☐	
District Nurse:	CSPCN:
Adult Care & Support:	Palliative Care Consultant:
Other Consultant:	Other:
Details of Referrer	
Full name:	
Designation:	
Address:	
Telephone number:	
Secure email (for feedback):	
Additional Comments	
FOR THERAPY TEAM ADMIN USE ONLY	
Advice Given	**Action Taken**
	<u>Appointed to</u>: **Outpatient: MEH ☐ SJH ☐** **Hub: Wadebridge ☐ Penzance ☐** **Home visit ☐** **<u>Inappropriate referral</u>** **Referred on to:** **Signposted to:** **Referrer advised:**
Name	Signature Date