



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 <input type="checkbox"/> Carer <input type="checkbox"/>		
Surname:	Title:	
First name:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Likes to be called:	Ethnicity:	
Date of birth:	NHS number:	
Address:		
Post code:		
Telephone:	Mobile:	
The person lives alone: Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Does not have capacity <input type="checkbox"/>		
Is the person already known to this service? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>		
Reason(s) for referral (tick all that apply and give further details if possible)		
<input type="checkbox"/> Symptom control advice <input type="checkbox"/> Emotional/psychological support <input type="checkbox"/> Advance Care Planning <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Mobility <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Social/financial support <input type="checkbox"/> 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):

Where did you hear about the hubs?

Additional Comments**FOR THERAPY TEAM ADMIN USE ONLY****Advice Given****Action Taken****Appointed to:**Outpatient: MEH SJH Hub: Wadebridge Penzance Home visit **Inappropriate referral**

Referred on to:

Signposted to:

Referrer advised:

Name

Signature

Date