Referral to Cornwall Hospice Care Neighbourhood Hub Service

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 mobility difficulties (please detail)	
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 ☐Complementary Therapy	
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**
	<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