Neighbourhood Hubs Referral Form

Name:
NHS Number:
Date Of Birth:

Please complete as much as possible and return this form to:

- communityservices@cornwallhospice.co.uk
- Cornwall Hospice Care, Neighbourhood Hubs Referrals, Porthpean Road, St Austell, PL26 6AB
- Telephone for queries: 01726 829874

There is a criteria for this service - this can be found on our website: www.cornwallhospicecare.co.uk or here Referral Criteria

Date:			
ABOUT THE PERSON YOU ARE REFERRING			
Full Name & Title:			
Likes to be called:		Gender:	
Date of birth:		NHS Number:	
Full Address (including postcode):			
Telephone:		Mobile:	
Does the person live alone?		If No, with whom?	
Has the person consented to this referral?			
Has the person given consent to access to their medical record?			
Person's GP:			
GP Name:		GP Telephone Number:	
GP Address:			
Emergency contact for the referred person:			
Full Name & Title:			
Full Address (including postcode):			
Telephone/mobile No:		Relationship to person referred:	
Reason(s) for referral ('X' 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:	
What difficulties is this person experiencing that are prompting this referral?			
What are you hoping to achieve for this person by referring them to us?			
Is the person you are referring a patient or carer?			
Now please go to the appropriate section and give as much details as possible.			

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PATIENT REFERRAL – Only complete if you are referring a patient	
Diagnosis (including dates, stage of disease……):	
Other relevant information (current symptoms/difficulties, medication/treatment, relevant past medical history, social circumstances such as care package, social support etc):	
Are there any risks visiting this person at home? (ie infection, pets, lone working). Please give details:	
Has a TEP form been completed or considered?	
Names of other professionals already involved:	
District Nurse:	CSPCN:
Palliative Care Consultant:	Other Consultant:
Adult Care and Support:	Other:
CARER REFERRAL – Only complete if you are referring a carer	
We can provide therapeutic support to the main unpaid carers of patients who would meet our eligibility criteria so we need information about the patient too.	
Patient's Full Name & Title:	
Patient's Date of Birth:	Patient's NHS Number:
Patient's Address (including postcode):	
Relationship to carer?	
ABOUT THE PERSON MAKING THE REFERRAL	
Full Name & Title:	Designation:
Address (including postcode):	
Telephone/Mobile Number(s):	
Secure Email (if clinician):	
Where did you hear about the hubs?	
ADDITIONAL COMMENTS – Any other information you wish to give us:	

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FOR THERAPY TEAM ADMIN USE ONLY		
NOTES:		OUTCOMES: Referral accepted Appointed to: Venue: Tel/video consultation Workshop Inappropriate referral Referred on to: Signposted to:
Name:	Signature:	Date: