East Lancashire Hospice
... a special way of caring

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REFERRAL FORM

Surname:	First name:		GP name and address Postcode: Telephone no: GP fax no:
Title:	Date of birth:	Preferred name:	
Address: Postcode:			
Tel No:	Mobile:		REFERRER Name:
NHS No:	Hospital No:		Base / Designation: Contact No:
Patient location at time of referral:			Care setting required *(please circle one option)* Outpatient Inpatient Hospice at Home *(hospice at home: complete and submit risk assessment with this referral form)*
Relevant diagnosis *(with dates):*			Other significant conditions:

Problem(s): *Please tell us what is happening with your patient that has prompted this referral.*
The detail you give will help us respond in the most timely manner with the most appropriate of our services.

Has the patient outlined their preferred priorities of care?	**Yes** / **No**	*(If yes please provide details)*
Lasting power of attorney (personal welfare)	**Yes** / **No**	*(If yes provide name and contact details)*

Signed:	Date:

For East Lancashire Hospice Use Only

Date and time referral received:	Date and time allocated:	Allocated to: *(specify service)*	Archive date:	Version Control ELH 28.10.2013 v3.1