East Lancashire Hospice

REFERRAL FORM

Palliative Care Physiotherapy; Creative & Support Therapies Complementary Therapy

Email to: admin.eastlancashirehospice@nhs.net

Telephone numbers for Clinical Administration: 01254 916983 / 965864

Please ensure you fully complete all sections as referrals will be triaged to determine priority. The detail in your information will support this process.

ACCEPTANCE CRITERIA: The individual being referred has a palliative/life-limiting condition.

In completing this form, you are confirming that your patient has consented to this referral and has the capacity to do so.

Individual referral forms for all other hospice services are available on the hospice website

Circle M / F	Title	First Name	Last Name	Preferred Name	
Date of Birth		Hospital Number	NHS Number	GP Name & Practice	
Address			Telephone Number		
			Mobile Number	Referrer Name (Please print)	
Post Code			Patient Location at time of referral	Referrer Role	
Main Diagnosis			Other Significant Conditions	Referrer Base	Contact Number
				Referrer Signature	Date

Service Required – tick or circle the relevant box

Palliative Care Physiotherapy	Creative & Support Therapies	Complementary Therapy
Aims to maximise independence and dignity and reduce the extent to which disease impacts on day-to-day life/activities. Patients are supported to develop skills to manage their symptoms such as breathlessness, pain, weakness and fatigue.	Aims to help patients develop strategies to overcome life's obstacles, increase confidence and independence, set personal goals, and be supported to achieve these, through creative therapeutic group activities.	Aims to support symptom management. It also gives 'time out' to enhance energy levels and restore equilibrium. An individualised treatment plan is developed after an initial assessment and taster session.

Rationale for Referral: Please provide as much information as possible including [1] what is happening with your patient at present [2] why your assessment has prompted this referral [3] the issues/concerns you believe the selected service can help address.

Does the patient have (please tick and provide details)

Access to this service elsewhere		
Any safeguarding concerns		
Communication difficulties		
Preferred place of care		
Preferred place of death		
A DNACPR order in place		
Just in case/Anticipatory medicines		
Uncontrolled symptoms/distress		

We may contact you should we require more detailed information to ensure we are able to meet your patient's needs.
Smoking is not permitted on hospice premises or in the grounds. Please ensure your patient is aware of this.