Complete all details to ensure your referral is not delayed
Fax: 720292 / email – communityteam@jerseyhospicecare.com

Jersey Hospice Care
your care, your choice, your time

EXTERNAL REFERRAL FORM

IS REFERRAL URGENT? (for assessment within 24 to 48 hours): Yes ☐ No ☐
IF YES, TELEPHONE SERVICE TO DISCUSS - 876555

Current location of patient: Home ☐ Nursing Home ☐ Residential Home ☐
Hospital ☐ **Ward name**:

Patient details

Surname:	**DOB:**	**Tel no:**
Forenames:	**Title:**	**Does the patient consent to the referral?** **Yes** ☐ **No** ☐ **If no, give reason:**
URN:		
Address: ADDRESSOGRAPH		**First contact details:**
		Relationship to patient:
		Tel no:
		Patient agrees to named person being contacted: **Yes** ☐ **No** ☐

GP and referrer's details

GP name	Referrer's name
GP surgery	Referrer's role
GP tel no	Referrer's tel no
If patient in the community is GP agreeable to referral? Yes ☐ No ☐	If patient is in hospital is the Consultant/Registrar agreeable to referral ? Yes ☐ No ☐

Reasons for referral

End of life care ☐	Emotional / Psychological support ☐
Symptom control ☐	Spiritual care / support ☐

Service requested

Outpatient appointment ☐ Community / Home visit ☐
Hospital based review ☐ Hospice admission ☐

GSF code	**Blue (A)** ☐ Year plus prognosis	**Green (B)** ☐ Months prognosis	**Amber (C)** ☐ Weeks prognosis	**Red (D)** ☐ Days prognosis

Key issues requiring Specialist Palliative Care input

Patients Name :_____ **DOB:** _____ **URN:**_____

Diagnosis

Comorbidities / Relevant Past Medical History

Allergies

Resuscitation status

Has a discussion regards CPR been undertaken?	Is DNACPR form in place?
Yes ☐ No ☐	Yes ☐ No ☐

Treatment Escalation Plan

Safeguarding

Are there any safeguarding issues (e.g. risk, abuse or neglect, SROL)

Risk assessments

Indicate if there are any potential risks or concerns that may affect patient, family or staff safety

(e.g. infections, drug or alcohol misuse, lone worker) Yes ☐ No ☐

Reason:

Communication

Language(s):	Is interpreter needed?
	Yes ☐ No ☐

Special considerations

Indicate any special considerations (e.g. cultural, ethnic, spiritual, gender, relationships, diet, body image, information sharing)

Referrers name:	**Signed:**
Role:	**Date:**