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| **Referral for Mountbatten Care Coordination Centre, Mountbatten Hampshire**  Community Palliative Care Team Hub - **02382 548860** Email: [referralshampshire@mountbatten.org.uk](mailto:referralshampshire@mountbatten.org.uk)  **Please ensure patients are aware information will be held on computer according to Data Protection Act**  **TO ENSURE TIMELY PROCESSING OF REFERRAL, PLEASE ENSURE ALL INFORMATION IS COMPLETE AND PATIENT HAS CONSENTED TO REFERRAL** | | | |
| **Date of referral:** | | | |
| **Patient full name (Title, First name and Surname:** *(required)* | | | |
| **Patient Address** *(required)* | | **Patient Postcode** *(required)* |  |
| **Date of Birth** *(required)* |  |
| **NHS number** *(required)* |  |
| **Home phone:**  **Mobile phone:** | **Name of GP** | |  |
| **GP Surgery** *(required)* | |  |
| **GP Surgery telephone number** | |  |

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| **Diagnosis**  *(required)* |  |
| **Relevant History** *(required)* |  |
| **Advance Care Planning has been discussed with the patient (if no, provide reason)** *(required)* | |
| **Yes □**  **No □** | |

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| **An Advance Care Plan has been documented and is held by the patient (if no, please give reason)** *(required)* |
| **Yes □**  **No** □ |
| **An Advance Decision to Refuse Treatment (ADRT) is in existence, relevant to the patients care** *(required)* |
| **Yes □ No □** |

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| **Reason for referral (please tick all that apply)** *(required)* | | | |
| Complex symptom control |  | Advance care planning |  |
| Introduction to service |  | Emotional/psychological support |  |
| Care whilst dying |  | Hazel Centre (Day Services) |  |
| Palliative Rehabilitation and Enablement- Occupational Therapy and Physiotherapy |  |

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| **Patient aware of referral?** | | **Yes □ No □** |
| **Other healthcare professional(s) involved?** | | **Yes □ No □** |
| **Consultants (please supply names)** *(required)* | | |
| **Urgency of referral** *(required)* | | |
| **Urgent** (maximum 2 working days) **□ Standard** (within 5 working days) **□** | | |
| **Mobility / Transport needs** *(required)* | | |
| **Yes □ No □** | | |
| **Additional Needs:** | | |
|  | | |
| **Any other information:** | | |
|  | | |
| **NOK / Significant other name** |  | |
| **NOK / Significant other contact number** |  | |

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| **Referrer full name** |  |
| **Contact number** |  |