**Community Specialist Palliative Care Team Referral Form**

**E-mail:** cpn-tr.spcreferral@nhs.net **or**

**Post: Community Specialist Palliative Care Team**

 **Truro Health Park, Infirmary Hill,**

 **Truro, TR1 2JA**



|  |  |
| --- | --- |
| Title: Surname:  | NHS Number:  |
| DOB: Age:  |
| Marital Status: |
| Ethnic Group:  |
| Forenames: Known as:  | Next of Kin/Carer:Relationship: Contact Number: |
| Address:Postcode: Telephone: Email Address: Lives Alone Y/N | Referrer Name: Designation: Place of Work:Telephone: Date of Referral:  |
| GP:  | Consultant: |
| Referred to DNs Y/N | Other: |
| Current Location of the Patient: | Confirmation that the patient has consented to this referral [ ]  | Is the GP aware of this referral? Y/N |
| Diagnosis: Date of Diagnosis | Site of any Metastases (if applicable) |
| **Reason for Referral**[ ]  Management and monitoring of persistent and/or transient symptoms[ ]  Management of complex emotional/psychological issues related to their palliative diagnosis[ ]  Management of complex social/family issues related to their palliative diagnosis[ ]  Planning complex end of life care |
| Urgent (contact within 2 working days) [ ]  | Routine (contact within 7days) [ ]  |
| **Main Symptoms/Problems:** |
| **Any Other Relevant Information:** |

**In the event that all information is not supplied we will need to contact you which may result in a delay.**