**Community Specialist Palliative Care Team Referral Form**

**E-mail:** [cpn-tr.spcreferral@nhs.net](mailto:cpn-tr.spcreferral@nhs.net) **or**

**Post: Community Specialist Palliative Care Team**

**Truro Health Park, Infirmary Hill,**

**Truro, TR1 2JA**

Graphical user interface, text

Description automatically generated

|  |  |  |  |
| --- | --- | --- | --- |
| 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.**