Community Specialist Palliative Care Team referral form

This form is for patients living in Cornwall and registered with a Cornwall-based GP surgery. E-mail completed forms to [cpn-tr.spcreferral@nhs.net](mailto:cpn-tr.spcreferral@nhs.net).

| **Title** | **Forename** | **Surname** | **Known as** |
| --- | --- | --- | --- |
|  |  |  |  |

| **NHS number** | **Date of birth** | **Age** |
| --- | --- | --- |
|  |  |  |

| **Ethnic group** | **Marital status** |
| --- | --- |
|  |  |

| **Next of kin** | **Relationship** | **Their contact number** |
| --- | --- | --- |
|  |  |  |

| **Address** | **Postcode** |
| --- | --- |
|  |  |

| **Telephone number** | **Email address** | **Lives alone?** |
| --- | --- | --- |
|  |  | Yes  No |

# Referral details

| **Referrer name** | **Designation** | **Place of work** |
| --- | --- | --- |
|  |  |  |

| **Telephone** | **Email address** | **Date of referral** |
| --- | --- | --- |
|  |  |  |

| **GP Surgery** | **Consultant** | **Is GP aware of referral?** |
| --- | --- | --- |
|  |  | Yes  No |

| **District nurse referral?** | **Other** | **Current location of patient** |
| --- | --- | --- |
|  |  |  |

| **Diagnosis** | **Date of diagnosis** | **Site of any metastases** |
| --- | --- | --- |
|  |  |  |

Confirmation that the patient has consented to this referral.

**Reason for referral**:

Management and monitoring of persistent and/or transient symptoms

Management of complex emotional or psychological issues related to their palliative diagnosis

Management of complex social or family issues related to their palliative diagnosis

Planning complex end of life care

**Referral urgency**:

Urgent (contact within 2 working days)  Routine (contact within 7 days)

| **Main symptoms and problems**: |
| --- |
|  |

| **Any other relevant information**: |
| --- |
|  |