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.

| **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**: |
| --- |
|  |