HOSPICE ISLE OF MAN
Referral Criteria
For access to services the patient should fulfil the three criteria below:

1. The patient has specialist palliative care needs.
2. The patient has active and progressive disease
3. Hospice IOM is the most appropriate agency to provide these services.

***Full Name:** **Known as:**	***NHS NO:** ***DOB**: **AGE:**
Is this referral URGENT Yes ☐ No ☐ **If so please state why and telephone the Community Team on 647475 before 9am.** **All referrals received will be triaged at 9.15am each day** Please ensure patients are aware this information will be held on computer according to the General Data Protection Regulations and that our privacy notice is available on the Hospice Isle of Man website. ***Does the patient agree to Hospice clinical staff accessing their GP and Hospital clinical record?** Yes ☐ No ☐ If No, is there any particular reason for this? Please state:	**Male** ☐ **Female** ☐ **Marital Status:** * **Patient Lives Alone:** Yes ☐ No ☐ ***Patient is currently:** ☐ In hospital Ward Name/ No: ☐ At home ☐ Elsewhere
* Address: *Post Code: *Telephone Number : Mobile Number: Email:	***General Practitioner** Name: Practice: Telephone: Is GP aware of referral? Yes ☐ No ☐
***Primary Diagnosis and Date of Diagnosis:** * **Known Metastases?** ***Treatments Given:** ***Current Treatment/Management Plan:**	***Professionals Involved:** Consultant: CNS:
***Please state clearly the reasons for referral for Specialist Palliative Care Input.**	***Allergies:**

***Past Medical History & Current Medication:**	
***Next Of Kin:** **Name:** **Address:** **Telephone No:** **Mobile No:** **Email:** **Does the Patient consent to us speaking to their Next of Kin?** Yes ☐ No ☐	***Awareness of Diagnosis /Referral to the Hospice** **Patient** **Family/Carer** **Diagnosis:** Yes ☐ No ☐ Yes ☐ No ☐ **Referral:** Yes ☐ No ☐ Yes ☐ No ☐ **What is the patient's understanding of their prognosis?** **What is the family/carer's understanding of the patient's prognosis?**
***Hospice Service Required:** ☐ Palliative Care CNS ☐ Fatigue & Breathlessness Programme ☐Complementary Therapy **Attendance:** Is the patient able to attend the Hospice for their appointment? Yes ☐ No ☐ ***Admission into Hospice In-Patient Unit for:** Terminal Care ☐ Symptom Management ☐	
***Source of Referral**: Name: Designation: Signature: Telephone Number: Date:	**Hospital use only** - Consultant aware of this referral? Yes ☐ No ☐ **Community use only** – GP aware of this referral? Yes ☐ No ☐

Please Email this Referral Form to: Referrals@hospice.org.im

This form can also be sent via EMIS. Please complete all Mandatory Sections marked * this form will be returned to sender to be completed. Please cc to patient's GP surgery for information. Please complete on line or with clear handwriting.

Referrals for Lymphoedema management must be on the dedicated Referral Form