REFERRAL FORM FOR SERVICES PROVIDED BY
HOSPICE ISLE OF MAN

NB: Referrals for Lymphoedema management must be on the dedicated Referral Form

Referral Criteria

1. The patient has specialist palliative care needs.
2. The patient has active and progressive disease

Surname:	First name(s):
NHS No: DOB	**Next of kin /Patient representative:** Name:
Address: Post Code: **Contact Telephone Number** :	Address: Telephone Contact
Male ☐ Female ☐	Relationship to patient:
Marital status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Cohabiting ☐ Widowed ☐ Unknown ☐	
Patient Lives Alone: Yes ☐ No ☐ **Patient is currently:** ☐ In hospital Ward: ☐ At home ☐ Elsewhere: Please state…….	**General Practitioner** Name: Practice: Telephone:
Diagnosis(es): **Please state Date of Diagnosis: ……**	**If Cancer; site of metastases (and date discovered)**
Past Medical History: **Details of current treatment plan:**	**Current Medication Taken:** **Allergies (including food)**

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Hospice Service Required:

☐ Palliative Care CNS ☐ Scholl Wellbeing Centre Day Therapy ☐ Social Worker
☐ Fatigue & Breathlessness Programme ☐Complementary Therapy ☐ Psychological Support
☐ Medical Outpatient Clinic

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☐ Respite Care☐

If a referral is urgent please state why and telephone the Community Team on 647475 before 9am

***All referrals received will be triaged at 9.15am each day**

Please state as fully as possible the main problems including symptoms?

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?

Source of Referral:
Name:

Address

Post code

Telephone Number:

Hospital use only - Consultant aware of this referral?
Yes ☐ No ☐

Community use only – GP aware of this referral?
Yes ☐ No ☐

Print Signature:

Designation: Date:

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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:

……

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

This form can also be sent via Emis.

Please cc to patient's GP surgery for information.

For Official Use Only: **Date referral received: ……**

PCCNS Triage: ……

Key Worker: …… **Date passed to key worker: ……**

Action/Outcome:

Signature: …… **Date: ……**