Referral to Hospice Isle of Man

All fields must be completed in full. Failure to complete this form correctly could lead to delay in service response or the referral being rejected.

Is the patient in the last few weeks of life (less than 4) (**TC**)	Yes ☐	No ☐
Does the patient have a palliative diagnosis (last 12 months of life) AND complex symptoms requiring hospice input (**SM**)	Yes ☐	No ☐

We can only accept patients in at least one of the above 2 categories.

PLEASE NOTE: We can no longer accept referrals for patients in the following categories **(unless the above criteria are met):**

- Those with no specialist palliative care symptoms
- Frailty
- Dementia
- Residents of Nursing Homes
- Any patient who also has another specialist nurse involved eg LTCC, Oncology, Cancer specialist nurse, Neurology nurse etc
- Palliative patients not in the last 4 weeks of life

Patient name		Reason for referral (please tick one)	TC ☐ Must be in the last weeks of life SM ☐ (see guidance below)
DOB			
Address		Urgent	Y ☐ or N ☐ If Urgent also ring 647475 or 647406 out of working hours
Phone number		DNACPR	Y ☐ or N ☐ If not we cannot accept ref for TC
NOK (inc contact detail and relationship)		TEP	Y ☐ or N ☐ If not we cannot accept ref for TC
Lives alone?	Y ☐ or N ☐	Package of Care?	Y ☐ or N ☐
Consent for referral ☐	Consent to record sharing ☐	Location of patient	Home ☐ Hospital ☐
Person completing the referral		GP details	

Main Diagnosis:

FOR TERMINAL CARE REFERRALS

Eating	Normal ☐	Less ☐	None ☐
Drinking	Normal ☐	Less/sips ☐	None ☐
Urination	Normal ☐	Less ☐	None ☐
Defaecation	Normal ☐	Loose ☐	Constipated ☐
Hours Asleep	Hours (in each 24 hour period)		
Mobility	Not bedbound ☐	Transfers to chair only ☐	Bedbound ☐
Consciousness	Conscious ☐	Semi-conscious ☐	Unconscious ☐
Prefer to die at Home ☐	Prefer to die at Hospice ☐	Prefer to die in Hospital ☐	
Blue MAR folder completed Y ☐ N ☐	Anticipatory medications Y ☐ N ☐		

FOR COMPLEX SYMPTOM MANAGEMENT REFERRALS

Symptom	Pain ☐ Nausea/vomiting ☐ Breathlessness ☐ Fatigue ☐ Agitation ☐ Difficulty with oral route ☐ Psychological distress ☐
Current management	
Previously tried	
Reason for referral	

Patients accepted onto the complex symptom management caseload, will be discharged back to the care of the referring team as soon as their symptoms are managed and a plan is in place. If further issues arise, re-referral would be needed.

Signature of referrer	
Email of referrer	
Date of referral	
For office use only:	

Disclaimer: Hospice Isle of Man is a charitable organisation providing specialist palliative and terminal care. The day-to-day care of the patient remains the responsibility of the referring team (if in hospital), or GP. We work on an advisory basis only, unless agreement is made to take over the patient's care completely eg admission to the inpatient unit. Completing this form acknowledges this and accepts the conditions of referral.

Please e-mail this referral form to: referrals@hospice.org.im