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|  | **Referral Form: Community Specialist**  **Palliative Care Team** |

**Urgent  Non Urgent  Date of referral:**

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| Patient name: NHS NUM:  **Preferred name:** |
| Address/current location: DoB:  Phone no: |
| NOK: Relationship: Contact details: |
| GP: |
| **Consent agreed for referral?** **Y  N**  **Please note that referrals will not be accepted unless the patient or main carer has consented to the referral** |
| **DIAGNOSIS :**  **Current/Planned Treatments:** |
| **We accept referrals for:** Patients with active, progressive, and life-limiting illness.  **MAIN CONCERNS - REASON FOR REFERRAL (please refer to SPC referral criteria):**  [download.cfm (yorkhospitals.nhs.uk)](https://staffroom.yorkhospitals.nhs.uk/download.cfm?ver=8009)  Please outline the main Complex Physical/Psychological/Social/ Spiritual Issues requiring specialist palliative care: |
| **Name of referrer/position: Contact number:**  A call will be made prior to contacting the patient if the referral form is not completed fully/ we require more information/or we are unclear of the Specialist palliative care need. |

**If the patient’s specialist needs are met, they will be discharged from the team’s caseload to the ongoing care of the key worker this will be done in collaboration with the patient**

**Electronic referrals can be made via system one**

Pleaseemail completed form to: yhs-tr.yorkcommunityspcreferrals@nhs.net

**FOR URGENT REFERRALS PLEASE RING 01904 777770 TO DISCUSS WITH THE TRIARGE NURSE**