Beaumond House Community Hospice Referral Form
FAX NO. 01636 613262

or post to Beaumond House 32 London Road Newark NG24 1TW – Tel: 01636 610556

Personal Details: Patient: ☐ Carer: ☐

Surname:	D.O.B	Age
First name(s):	NHS No:	
Address: Post Code:		
Telephone Home:	Mobile:	
Male/Female	Marital status:	
Ethnicity:	Religion/spiritual needs:	
Primary diagnosis and date diagnosis made :		
Other diagnoses:		
Insight and Mental Capacity: Is the Person aware of this referral Yes No Does the person have any medical or other issues that could impair their mental capacity? Yes No		

Next of kin /Patient representative:

Name:

Address:

Telephone Home:

Mobile:

Relationship to patient:

Main carer (if different from next of kin)

Name:

Address:

Telephone:

Mobile:

Relationship to patient:

The patient is currently:

At home:

In hospital:

Elsewhere:

Does patient live alone?
Yes No

Lives with .....

Mobility: Independent: ☐

Needs Assisting: ☐

Mostly Bed Bound: ☐

Estimated Prognosis:

Days: ☐

Weeks: ☐

3-6 Months ☐

6-12 Months ☐

Services Requested:

In Patient	□
Day Care	□
Hospice at Home	□
Complementary Therapy	□
Carer Support	□
Bereavement support	□
Equipment Loan	□
Financial advice	□

DS1500 applied for: Yes No

Fast track Applied for:

Yes No

Status:.....

General Practitioner:

Name:

Practice:

Telephone:

Fax:

Specialist Nurse involved:

Name:

Contact No:

Other Key Professionals:

Name

Contact No:

Name

Contact No:

Any Advanced Care Planning Decisions: Preferred Place of Care: Preferred Place of Death: Advanced decision to refuse treatment: Yes No	Has CPR been discussed: Yes No By whom: DNACPR Completed: Yes No By Whom:
Relevant Past Medical History:	
Recent Chemotherapy /Radiotherapy Treatment:	
Allergies:	
Any infection issues: eg: MRSA CDiff	On Oxygen: Yes No
Main problems, symptoms and reason for referral:	
Referrers signature: **Name: (please print)** **Job title:** **Contact number:** **Date:** Please fax copies of recent clinical correspondence with this form	
For official Use only:	
Date referred	BH Planning Date
GP coding colour	Home Visit applicable
GSF Needs Coding sticker	Assessed By:
OR Long term condition patient	Assessed On: