

# South Glasgow Palliative Care Services Referral



Surname:	Date Referred	Referrer:	Designation:
First name:			
Address:	Consultant ①:	Oncologist/Consultant ②:	
Post Code:	Next of Kin:		
Telephone:			
D.O.B.:	Relationship to Patient:		
CHI. number:	Contact No:		
G.P.:	Main Carer (if different from above):		
Address:			
	Contact No.:		
	Hospital Number:		
Post Code:	Religion:		
Telephone:	M W S DIV SEP		
Diagnosis:	For non cancer diagnosis, please give brief history:		
Date of Diagnosis:			
Secondary sites			
Date of Diagnosis:			
Previous treatments:			
Describe patient's understanding of disease and prognosis:			
Have relatives been told of diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Is patient aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are relatives aware of referral to Palliative Care Services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Any other relevant information? (e.g. current or planned treatment):			
Co-existing medical conditions / past medical history:			
Allergies:			

## Palliative Care Services - Referral Form Part 2

Patient' name:

Hospital number:

D.o.B.:

Patient Currently at:	Home <input type="checkbox"/>	Hospital <input type="checkbox"/>	Ward <input type="checkbox"/>	Ward Ext No	Nursing Home <input type="checkbox"/>
		SGH <input type="checkbox"/>			
		Victoria <input type="checkbox"/>			
		Mansion House Unit <input type="checkbox"/>			
		Mearnskirk <input type="checkbox"/>			
		Other <input type="checkbox"/>			

Is District Nurse in Attendance? Yes  No  Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Which Service is Required?

Hospital Review / Assessment <input type="checkbox"/>	Laurieston Nurse <input type="checkbox"/>
Symptom Control Clinic (outpatient only) <input type="checkbox"/>	

### Reason for Referral

The following are some areas for referring a patient for specialist palliative care. Please circle the severity of the following from 1-4, 1 being mild and 4 overwhelming.

Agitation	1	2	3	4	Family Distress	1	2	3	4								
Nausea	1	2	3	4	Spiritual / Existential Distress	1	2	3	4								
Vomiting	1	2	3	4	Distress due to care environment	1	2	3	4								
Dyspnoea	1	2	3	4	Other, Please specify:	1	2	3	4								
Constipation	1	2	3	4	Other, Please specify:	1	2	3	4								
Patient Distress	1	2	3	4	End of Life: (Last 48 - 72 hours of life)	Yes <input type="checkbox"/> No <input type="checkbox"/>											
Depression	1	2	3	4	No pain	0	1	2	3	4	5	6	7	8	9	10	Severe pain
						Mild			Moderate			Severe					

### Additional Information