**Manchester Macmillan Supportive and Palliative Care Service**

**Adult Referral Form**

**IF YOUR REFERRAL IS URGENT PLEASE CONTACT THE OFFICE**

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| **PATIENT DETAILS** Surname ………………………….………..First Name ……………………………………..….Known as ….…………...................…Address ……………………………………… …………………………….......Post Code …………………………….Telephone …………………………….NHS number. ....................................Date of Birth ………………………… | **Gender** Male / Female / Other**Civil Status;** Married/Separated  Civil Partnership  Single Widowed Divorced Cohabiting Occupation (or last occupation)…………………………........Lives alone Yes/No | **Ethnic Status** – please tickWhite British Black CaribbeanWhite Irish Black AfricanOther white Other BlackIndian ChinesePakistani OtherBangladeshi Not statedOther Asian Mixed white/black Caribbean Mixed white/black African Mixed white/Asian Other mixedLanguage.................................................Is interpreter required; Yes/No Religion ……………..……………………. |
| **Does the patient consent to the referral?** Yes / No **Is the patient’s next of kin aware of the referral?** Yes / No**Has the patient given consent for their information to be shared?** Yes / No |
| **NEXT OF KIN DETAILS**Surname …………………………………………Name ………………...……………………….Relationship ………………………………………....Address…….……………………..….…..………………………………..…...…………………………………..…….Post Code ….…………...……………Telephone …………………………… | **GENERAL PRACTITIONER**Name ……………………………...…Practice……………………………….Address………………………………………………………………………..Post Code ………………………..…Telephone ………………………..…Fax……………………………………NHS.Net Email………………………………………..GP aware of referral: Yes/No | **REFERRER DETAILS**Name ………………………………………Designation ...…………...........................Department ………………………………Address ………………………………………………….........……….…………………Post Code ….…………………………….Telephone............………..…..…...………Fax…………..…...………….…………….NHS.Net Email……………………………………..…….. |
| **Diagnosis (e.g. Primary and secondary cancer, non-malignant disease)**Date(s) of diagnosis:**Is patient aware of their diagnosis?** Yes / No**Is the patient aware of their prognosis?** Yes / No |
| ***PLEASE SEND COPIES OF RELEVENT CLINICAL CORRESPONDENCE WITH THIS FORM*** |
| **Current Services Involved** | **Name** | **Base** | **Telephone No.** |
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| **Current Problems** |
| 1.Activities of daily living |  | 9. Exercise rehabilitation |  | 17. Nutrition |  |
| 2. Assessment |  | 10. Family support & advice |  | 18. Pain & Symptom Management |  |
| 3. Bereavement support |  | 11. Fatigue |  | 19. Palliative Care |  |
| 4. Body Image |  | 12. Goal setting |  | 20. Psychological Support |  |
| 5. Breathlessness |  | 13. Indirect contact/advice |  | 21. Respiratory |  |
| 6. Speech & Voice |  | 14. Lymphoedema |  | 22. Stress/anxiety management |  |
| 7. Dysphagia |  | 15 Mobility |  | 23. Supportive D/C |  |
| 8. End of Life Care |  | 16. Moving and Handling |  | 24. Vocational |  |
| **CURRENT MEDICATION + ALLERGIES** | **PAST MEDICAL HISTORY**Has the patient been fitted with:a) A cardiac pacemaker/ implanted defibrillator? YES/NOb) Radioactive or other implant? YES/NO |
| **SOCIAL SITUATION**e.g. housing, family, financial |
| **Please tick box if following has been discussed/is in place** Palliative Care Register Six Steps register Anticipatory DrugsDo Not Attempt Resuscitation Statement of Intent Preferred Priorities CareLiving Will/Advance Directive Power of Attorney Power of Attorney (Health & Welfare) (Property & Financial)CHC applied for Yes /No Date submitted:RESPECT form/Advanced Care Plan/DNAR Yes/No |
| Please clearly state what the priorities are for the first visit including information of any screening tool (MUST, Pain Assessment etc) and treatments carried out. |
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| **Referrers Signature: Date of Referral:** |