

**COMMUNITY SPECIALIST PALLIATIVE CARE**

**OCCUPATIONAL THERAPY SERVICE**

**REFERRAL FORM**

 Specialist Palliative Care Occupational Therapy

Southgate Moorings

2 Kimbrose Way

Gloucester

GL1 2DB

01452 393852

 **Please email your referral to:** PalliativeOTTeam@glos-care.nhs.uk

**PATIENT DETAILS**

|  |  |
| --- | --- |
| Name: | NHS No: |
| Address (or inpatient sticker):Postcode:Telephone: | Date of birth: |
| Next of kin/carer: |
| Contact No: |
| Relationship: |
| Current address (if different from above): | Relevant family issues: |
| Diagnosis (including date of diagnosis/site of metastases:Resus Status :  | Past Medical History: |
| AWARENESS:Is the Patient aware of this referral? Yes / No | How much does the patient know about the diagnosis/Prognosis? (Please tick) |
| Most □ | Little □ | Nothing □ |

**REASON FOR SPECIALIST OCCUPATIONAL THERAPY REFERRAL**

**(Overview of current situation & functional issues)**

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|  |
| **Referrer Name (Print):** | **Telephone Number:** |
| **Job Title & Place of Work:** | **Date of Referral:** |

**Patient name: Date of birth:**

|  |
| --- |
| **TREATMENT DETAILS IF KNOWN:** |
| **Surgery:** | **Surgery date:** |
| **Chemotherapy:** | **Commenced Yes / No****Completed Yes / No** |
| **Radiotherapy:**  | **Commenced Yes / No****Completed Yes / No** |
| **Current Medication:** | **Investigations outstanding:** |
| **CONSULTANTS:** | **Who Else Is Involved in Patient’s Care?** |

**In the event that all required information is not supplied, the referral form will be returned for completion.**

**FOR OFFICE USE ONLY**

|  |  |  |
| --- | --- | --- |
| Date referral received: | Priority level of intervention: | Date registered & scanned on toSystmOne: |