

**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](mailto: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)**

|  |  |
| --- | --- |
|  | |
| **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 to  SystmOne: |