

General Referral Form for Myton Hospices (please see Referral Guidance on website)



Please tick **Patient's Preferred location(s)** for care:

Inpatient Care at	Warwick <input type="checkbox"/>	Coventry <input type="checkbox"/>	Either <input type="checkbox"/>	
Day Hospice at	Warwick <input type="checkbox"/>	Coventry <input type="checkbox"/>	Rugby <input type="checkbox"/>	Any <input type="checkbox"/>

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For all referrals please **complete section A & B in full** AND appropriate **section(s) on page 2:**

Page 1 of 2

SECTION A: PATIENT DETAILS	
Patient's name: DOB: NHS Number: Address: Postcode: Tel. no: Known to Myton: Yes <input type="checkbox"/> PID:	M / F No <input type="checkbox"/>
GP name: Practice: Address: Tel. no:	
Next Of Kin: Relationship: Tel. no: Main carer if not NOK:	District Nurse: Patient known to DN: Yes <input type="checkbox"/> No <input type="checkbox"/> Base: Tel: Patient known to Community Matron: Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Tel:
Consultant: Specialty: Hospital:	Clinical Nurse Specialist: Specialty (eg Pall Care/Renal etc): Tel. no:
Patient's present location: If at home, lives with:	Other services involved: (eg carers, Marie Curie sitters) Continuing Care Funding: Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/>
or Alone: <input type="checkbox"/>	
SECTION B: CLINICAL DETAILS	
Diagnosis: Date originally diagnosed:	
Stage: eg Cancer[metastases, site, date], Renal Failure [GFR], COPD [FEV1, no. exac.s/last 12months], Heart Failure [NYHA class]	
Estimated prognosis: Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/>	
Other significant Medical conditions:	
Active Hospital Treatment within last month: (State None or give details) Oncological: (eg Radio-/Chemotherapy) Medical: (eg Dialysis – type/when) Surgical: Other (please state):	
Current problem list: Physical (incl. symptoms and severity)/Emotional/Psychological/Spiritual (give details on p 2) 1. 2. 3. 4.	
Particular requirements for patient: (eg communication/mobility/equipment/family/personal)	
Children (0-18yrs) involved: Yes <input type="checkbox"/> No <input type="checkbox"/> CPR status: For CPR <input type="checkbox"/> Not for CPR <input type="checkbox"/> Decision not made <input type="checkbox"/>	
Patient fully aware of: Diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Prognosis: Yes <input type="checkbox"/> No <input type="checkbox"/>	
This referral: Yes <input type="checkbox"/> No <input type="checkbox"/> Referral should be considered to be in patient's best interests if patient cannot consent	
PLEASE COMPLETE REFERERS DETAILS ON BOTH PAGES	
Referrer's Name:	Title:
Tel. no:	
Date of Referral:	We will use this Tel. no. to contact you if we need further information
NOW PLEASE COMPLETE RELEVANT SECTION(S) ON PAGE 2	



Patient's name:	DOB:
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SECTION C: REFERRAL FOR MYTON INPATIENT CARE
Myton Hospices Central Allocation Fax No: 01926 838 894

WARWICK MYTON HOSPICE INPATIENT UNIT Tel. no. 01926 492 518 x 210 or 211	COVENTRY MYTON HOSPICE INPATIENT UNIT Tel. no. 02476 841 900 (CMH reception)
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Reason for admission: (Please tick box(es) which best describe patient's need)
 Symptom control Terminal Care Respite Rehabilitation Psychological Support
 (Please give further details below including current treatments/ treatments already tried)

What you are hoping patient will gain from admission to Myton Hospice:

Urgency of admission: Within 48 hrs Less than One week Over One week
 Reason for this urgency:

SECTION D: REFERRAL FOR MYTON DAY HOSPICE
Myton Hospices Central Allocation Fax No: 01926 838 894

WARWICK MYTON DAY HOSPICE Tel. no. 01926 492 518 x 209	RUGBY MYTON DAY HOSPICE Tel. no. 01788 550 085	COVENTRY MYTON DAY HOSPICE Tel. no 02476 841 900 (CMH reception)
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Reason for referral: (Please tick box(es) which best describe patient's need)
 Psychological Support Social Support Symptom monitoring/management Other
 (Please give further details below)

What you are hoping patient will gain from attending Myton Day Hospice:

If patient can travel by car: Yes No **or by Ambulance:** Yes No

PLEASE COMPLETE REFERERS DETAILS ON BOTH PAGES

Referrer's Name:	Title:	Tel. no:
Date of Referral: _____ We will use this Tel. no. to contact you if we need further information		

NOW PLEASE **FAX** TO MYTON HOSPICES CENTRAL ALLOCATION FAX NO: **01926 838 894**
 INCLUDE COPY OF **RELEVANT CLINICAL CORRESPONDENCE**
 (AT LEAST LAST 3 RELEVANT CLINIC LETTERS/REVIEWS WITH MOST **RECENT SCAN/BLOOD** RESULTS)
 AND ENSURE ADMITTED PATIENT BRINGS **CURRENT MEDS** (IF NOT THEN UP-TO-DATE LIST) - THANK YOU!