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

Please tick patient's preferred location and whether patient will accept either hospice for inpatient care?

Inpatient Care at	Warwick ☐	Coventry ☐	Either ☐	
Day Hospice at	Warwick ☐	Coventry ☐	Rugby ☐	Any ☐
Booked Respite ☐				

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

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

SECTION A : PATIENT DETAILS

Patient's name: **M / F** DOB: NHS Number: Address: Postcode: Tel. no: Known to Myton: Yes ☐ No ☐	**GP name:** Practice: Address: Tel. no:
Next of Kin: Relationship: Tel. no: Main carer if not NOK:	**District Nurse:** Patient known to DN: Yes ☐ No ☐ Base: Tel. no: Patient known to community Matron: Yes ☐ No ☐ Name:
Consultant: Specialty: Hospital:	**Clinical Nurse Specialist:** Speciality (eg Pall Care/Renal etc): Tel. no:
Patient's present location: If at home, lives with: or alone: ☐	**Other Services involved:** (eg carers, Marie Curie sitters) Continuing Care Funding: Yes ☐ No ☐ Referred ☐

SECTION B : CLINICAL DETAILS

Diagnosis:

Date originally diagnosed:

Stage:

Eg Cancer [Metastases, site, date], Renal failure [GFR], COPD [FEV1, no. Exac.s/last 12 months], Heart Failure [NYHA class]

Estimated Prognisis: Days ☐ Weeks ☐ Months ☐ Years ☐

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 (icl. Symptoms and severity)/Emotional/Psychological/Spiritual (give details on p.2)
1.
2.
3.
4.

Children (0-18yrs) involved: Yes ☐ No ☐ **CPR Status:** For CPR ☐ Not for CPR ☐ Decision not made ☐

Patient full aware of: **Diagnosis:** Yes ☐ No ☐ **Prognosis:** Yes ☐ No ☐

This referral: Yes ☐ No ☐ Referral should be considered to be in patient's best interests if patient cannot consent

PLEASE COMPLETE REFERRERS 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:**

SECTION C: REFERRAL FOR MYTON INPATIENT CARE
Myton Hospice Central Allocation Fax no: 01926 495455

Reason for admission: Please tick box(es) which best describe patient's need (Please refer to admission criteria)
Symptom Control ☐ Terminal Care ☐ Respite ☐ Rehabilitation ☐ Psychological Support ☐

(Please give further details below including current treatments and treatments already tried)

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

SECTION D : REFERRAL FOR MYTON DAY HOSPICE
Myton Hospices Central allocation Fax no: 01926 495455

WARWICK MYTON DAY HOSPICE	**RUGBY MYTON DAY HOSPICE**	**COVENTRY MYTON DAY HOSPICE**
Tel. no. 01926 492 518 ext 354	Tel. no. 01788 550 085 ext 104 or 105	Tel. no. 02476 841 900 ext 6036 6070

Reason for referral: (Please tick box(es) which best escribed patient's need)
Psychological Support ☐ Social Support ☐ Symptom monitoring/management ☐ Other ☐

(Please give further details below)

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

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

PLEASE COMPLETE REFERRERS 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

Include copy of **relevant clinical correspondence** (at least last 2 relevant clinic letters/reviews with most **recent scan/blood** results) and ensure patient brings **current meds** (if not then an up-to-date list)

Referral and Discharge Team telephone number 01926 838889

NOW PLEASE FAX TO MYTON HOSPICES CENTRAL ALLOCATION FAX NO: 01926 495455