PATIENT REFERRALS

Please provide the details of the patient being referred:

Patient name:	
Title:	
Prefers to be called:	
Date of birth:	
Home address:	
County:	
Postcode:	
Phone numbers:	
Email address:	
Best time and means of contact:	

Please provide the details of the patient's next of kin:

Name and relationship to patient:	
Phone number:	
Does the patient live alone?	

Please provide your details:

The details of the person making the referral.

Your name:	
Job title:	
Relationship to patient:	
Phone:	
Email:	
How did you hear about Skanda Vale Hospice?	

☐ I confirm that the patient is aware of this referral.

☐ I confirm that the patient has given consent for this referral.

Which of our services do you think would be of most benefit to the patient? *Please select any that apply.*

☐ Overnight Respite

☐ Day Hospice

☐ Remote Companionship

☐ Complementary Therapies

☐ Support for family / carers

☐ Advance Care Planning

☐ Information and / or signposting

☐ Bereavement Support

☐ Spiritual Support

☐ Social Support

☐ Emotional Support

☐ Psychological Support

☐ Physical Care

☐ Assisted Bathing

Please tell us about the patient—their diagnosis, prognosis and needs.

Are there any particular issues that we should know about?
Please tick any that apply

- ☐ Safeguarding
- ☐ Capacity
- ☐ Infectious disease
- ☐ Sensitivity with diagnosis or personal circumstances
- ☐ History of violence / aggression

If you answered 'yes', please tell us more:

Which GP surgery is the patient registered with?

Name of patient's GP:

The contact number of patient's GP:

Signed: Date:

Please print and post to:
Nursing Team, Skanda Vale Hospice, Saron, Llandysul, SA44 5DY.