If patient needs to be seen immediately please
Telephone: 01495 717277 Fax: 01495 724188

Office use:	**iCARE:**	**ISCO:**	**CWS:**

Date of Referral:	**Routine Yes / No** (needs to be seen in 2-7 days)	**Urgent Yes / No** (needs to be seen in 24 – 48hours)

Patients Name: Address: Postcode: Tel No:	**GP:** Address: Tel No:
Date of Birth:	**GP informed**: Yes [ ] No [ ] Not known [ ]

Main Carer: Relationship Address: Tel No:	**Consultant / CNS** Hospital: Hospital No:	
	District Nurse:	**OT:**
Main life-limiting diagnosis:	**Social Worker:**	**Physiotherapy:**
Date of Diagnosis:	**Social Situation:** Lives alone: Yes/No Mobile: Yes/No	
Severity and/or extent of disease:	**Any staff safety issues?** Yes / No	
Other medical diagnoses:	**Please list risk management strategies?**	
Current/previous treatment (s):	**Patient aware of:** Referral: YES / NO If no, why? Diagnosis: YES / NO / UNSURE Prognosis: YES / NO / UNSURE	
Medication:	**Problems/comments:**	
Reason for referral: Symptom control: [ ] Psychological support for patient: [ ] Psychological support for carer: [ ] End of Life Care: [ ] Other: [ ]	**Referred by:** **Tel No:**	
	Referral reviewed by:	**Date:**
	Action planned:	

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