CONFIDENTIAL

Hospice at Home West Cumbria Family and Bereavement Support Team Referral Form
Contact To Be Made Within 10 Days

Referral for: FABS yes / no Complementary Therapies yes / no	Patient Carer Bereaved Patient diagnosis: Has the client given consent for referral? yes/no Does the client have capacity? yes/no If patient, DNACPR?
HHWC supports: - Patients who have a palliative diagnosis who are believed to be in the last 12 months of life and are known to HHWC or Specialist Palliative Care Team. - Their family members. - Their family members into bereavement*. *Please note we do not offer a bereavement counselling service. Confirm the person referred meets criteria yes / no	

Name	Preferred name	Date of birth
Address Phone Email Preference	Emis number NHS number GP	Referred by Role Phone / contact
Ethnic origin	Religion	Learning disability &/or autism

Main concerns that have led to referral:

Example: PATIENT: pain, nausea, insomnia, side effects of medications, struggling to come to terms with prognosis, anxiety about procedures / results / treatment / progression, fatigue, angry at diagnosis, unable to relax, agitation, preparatory grief, would benefit from exploring coping strategies, would benefit from meeting others with a similar experience (group).

Example: FAMILY: anxiety about prognosis / progression, elevated stress levels due to caring role, insomnia, struggling to process grief or anticipatory grief, feelings of overwhelm, feelings of isolation due to caring role, loss of identity, fear of not coping with bereavement, would benefit from talking and processing thoughts and feelings around illness/ death/dying/bereavement,

CONFIDENTIAL

Hospice at Home West Cumbria Family and Bereavement Support Team Referral Form
Contact To Be Made Within 10 Days

Would benefit from exploring coping strategies, would benefit from meeting others with a similar experience (group). Would benefit from bereavement support because…
Additional support requirements, e.g. hearing/visual impairments, dementia, communication: **Please note that we are unable to offer support to those with significant mental health problems as this is beyond the scope of our service. Please refer to GP or specialist services.**

Next of kin / contact person:
Address:

If carer: details of patient below: If bereaved: details of deceased below: Name: Address:	Relationship to referred person: Known to Specialist Palliative Care Team? Date of death:

DATE

SIGNED

To make a referral to Hospice at Home West Cumbria, please complete this form and email it to: adminhahwc@hhwc.cumbria.nhs.uk