



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.

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

Overnight Respite

Bereavement Support

Day Hospice

Spiritual Support

Remote Companionship

Social Support

Complementary Therapies

Emotional Support

Support for family / carers

Psychological Support

Advance Care Planning

Physical Care

Information and / or signposting

Assisted Bathing

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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

Sensitivity with diagnosis
or personal circumstances

Capacity

History of violence / aggression

Infectious disease

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 email to: care.enquiries@skandavalehospice.org or print and post to:
Nursing Team, Skanda Vale Hospice, Saron, Llandysul, SA44 5DY.