General Referral Form for The Myton Hospices
Please see Referral Guidance at www.mytonhospice.org/refer

Please tick patient's preferred location and whether patient will accept either Day Hospice or 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

Patients 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:
Patients 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 Prognosis: 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 (inc Symptoms and severity)/Emotional/Psychological/Spiritual (give details on page 2)
1.
2.
3.
4.

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

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

This Referral: Yes ☐ No ☐

Referral should be considered in the patients best interests if patient cannot consent

PLEASE COMPLETE REFERRERS DETAILS ON BOTH PAGES

Referrers Name: **Title:** **Tel No:**

Date of Referral: We will use this tel no. to contact you if we need further information

NOW COMPLETE RELEVANT SECTION(S) ON PAGE 2

Patients Name:	**DOB:**

Section C: REFERRAL FOR MYTON INPATIENT CARE

Reason for admission: Please tick box(es) which best describe patient's need (Refer to admission criteria)

Symptom Control ☐ Terminal Care ☐ Respite Care ☐ 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?

SECTION D: REFERRAL FOR MYTON DAY HOSPICE

WARWICK MYTON DAY HOSPICE	**RUGBY MYTON DAY HOSPICE**	**COVENTRY MYTON DAY HOSPICE**
Tel. no. 01926 492518 ext 354	Tel. no. 01788 550085 ext 104 or 105	Tel. no. 02476 841900 ext 6036/6070

Reason for referral: (Please tick box(es) which best describe patient's need(s)

Psychological Support ☐ Social Support ☐ Symptom monitoring/management ☐ Other ☐

(Please give further details below)

What are you hoping the patient will gain from referral to Myton Day Hospice?

Can the patient travel by car: Yes ☐ No ☐ **Or by Ambulance:** Yes ☐ No ☐

PLEASE COMPLETE REFERRERS DETAILS ON BOTH PAGES

Referrers 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