LEWIS-MANNING HOSPICE
OUTPATIENT PHYSIOTHERAPY REFERRAL FORM

Post to: Physiotherapy Department, Lewis-Manning Hospice **Tel:** 01202 708470
Fax to: 01202 672660
This referral form can be downloaded from the website: www.lewis-manning.co.uk

1. ESSENTIAL PATIENT INFORMATION		
Patient's Name	**Patient's Address with Post Code**	**Telephone Number**
Date of Birth		**Patient aware of referral** **Yes ☐ No ☐**
Next of Kin	**NOK Contact Telephone Number**	**NHS Number:**

2. REFERRED BY		
Name and position	**Contact number**	**Signature & Date**

3. PATIENT'S GP AND SURGERY	**4. OTHERS INVOLVED** (name and phone number where possible)
Telephone No	• **Hospital Consultant(s)** • **District Nurses** • **Specialist Nurses**
GP aware of referral Yes ☐ No ☐	

5. DIAGNOSIS:	**Patient Aware Yes ☐ No ☐**
DATE OF DIAGNOSIS:	**Relatives aware Yes ☐ No ☐**
STAGE OF DISEASE:	

RECENT TREATMENT HISTORY inc. dates (chemo/radiotherapy/surgery/medical intervention/investigations)

REASON FOR REFERRAL/AIMS OF PHYSIOTHERAPY

Name in Capitals	**Signature**	**Date**

Transport

Will Patient or Carer need transport to the hospice Yes ☐ No ☐

Will Patient need assistance of more than 1 person to get into car Yes ☐ No ☐

If **Yes**, please specify help required: ……...
……...

Details of level of disability: ……..
……...

Details of walking aids used/needed: ……..

Deafness ☐ Visual Impairment ☐ Confusion/memory problems ☐

Balance problems ☐ Co-ordination/spasm/paralysis ☐ Pain on movement ☐

Oedema ☐ Anxiety/Panic Attacks ☐ Obesity ☐

Is Patient able to manage steps Yes ☐ No ☐ Independent Yes ☐ No ☐

Is Patient able to manage slope Yes ☐ No ☐ Independent Yes ☐ No ☐

Level walking distance manageable:

10 metres minimum Yes ☐ No ☐ Independent Yes ☐ No ☐

If **No**, details of aids/assistance required: ……..