**LEWIS-MANNING HOSPICE**

**OUTPATIENT PHYSIOTHERAPY REFERRAL FORM**

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| **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**  |

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| **1. ESSENTIAL PATIENT INFORMATION** |
| Patient’s Name | Patient’s Address with Post Code | **Telephone Number** |
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| **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)* **Hospital Consultant(s)**
* **District Nurses**
* **Specialist Nurses**
 |
| **Telephone No** |
| **GP aware of referral**  **Yes No**  |
| 5. DIAGNOSIS: **DATE OF DIAGNOSIS:** **STAGE OF DISEASE:** | **Patient Aware**  **Yes No** Relatives aware Yes No  |
| **RECENT TREATMENT HISTORY** inc. dates(chemo/radiotherapy/surgery/medical intervention/investigations) |
| **REASON FOR REFERRAL/AIMS OF PHYSIOTHERAPY** |
| **Name in Capitals** | **Signature** | **Date** |

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| **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: ……………………………………………………………………………….  |
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