**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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