St. Clare's Hospice

registered charity no.

DAY CARE REQUEST FOR ASSESSMENT

Referred by: …… Tel. No. ……

Received by: …… Date ……

Patient's Details

NHS No…… Pass No……

Name …… DOB:……..

Address……

Post Code ……..…… Tel. No. ……..……..

Religion…….. Where is patient today? ……

Expected date of discharge (if in Hospital) ……

NOK…… Address……..

…… Relationship…… Tel. No. ……

Consultant / Hospital …… GP……

GPs Address…… Tel. No……..

Diagnosis……

Is patient aware of diagnosis? Yes / No Is family aware of diagnosis? Yes / No

Is patient aware of referral? Yes / No Is family aware of referral? Yes / No

Is the patient aware of a 6 week re assessment / plan……

Other referrals made: -

District Nurse …….. Tel. No. ……..

Macmillan Nurse …… Tel. No. ……

Other services involved……..

Social / Home circumstances ……

Present Medication ……

Recent History……

……

Recent Treatment / Blood Results……..

……

Clinical problems now / Reason for referral ……

Any current / previous infections i.e. MRSA, C.Diff. ……..

Transport Risk Assessment

Patients Name……

Address……..

Contact Details……

Any problems with access to property…….

Can the patient transfer safely from their property to the transport vehicle

……..

Does the patient have any mobility problems……..

Any advice for the driver……

Does the patient suffer from travel sickness……..

Will the patient be carrying transportable oxygen during their journey to the hospice and home ……

Name of person completing this risk assessment……..

Date of assessment……

Please note: Risk Assessments to be completed prior to patient attending day care. These will be filed in the patients notes